Prior Authorization Criteria

2020

For information on obtaining an updated coverage determination or an exception to a coverage determination please contact Optimum HealthCare Member Services at 1-866-245-5360 or, for TTY/TDD users 711. Our hours are October 1 to February 14 from 8:00 am to 8:00 pm 7 days a week and February 15 to September 30 from 8:00 am to 8:00 pm Monday through Friday or visit www.youroptimumhealthcare.com.

For an indexed list of drugs please go to page 311.

Last Updated 02/01/2020

Actemra

Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	Tuberculosis, or invasive fungal infections or other active serious infections, or history if recurrent infections. Individuals who have not had a tuberculin skin test or Center for Disease Control recommended equivalent to evaluate for latent tuberculosis prior to initiating Actemra (tocilizumab). Using Actemra in combination with other TNF antagonists, IL-1R antagonists, janus kinase inhibitor, anti-cd20 monoclonal antibodies or selective co-stimulation modulators. At initiation of therapy, absolute neutrophil count (ANC) below 2000/mm3, platelet count below 100,000/mm3, or ALT or AST above 1.5 times the upper limit of normal.
Required Medical Information	
Age Restrictions	individual is 18 years of age or older, except for the diagnosis of JIA, PJIA. For JIA, PJIA patient is 2 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For rheumatoid arthritis (RA), Individual has had an inadequate response to ONE non-biological or biologic disease modifying anti-rheumatic drug (DMARD) such as methotrexate (MTX) or a tumor necrosis factor (TNF) antagonist drug AND individual has had a trial and inadequate response or intolerance to: Humira(adalimumab) OR Enbrel(etanercept). For Systemic Juvenile Idiopathic Arthritis (SJIA), agent is being used to reduce signs/symptoms or induce/maintain clinical response. Individual has failed to respond to, is tolerant of, or has a medical contraindication to ONE corticosteroid or nonsteroidal anti-inflammatory drug (NSAID). For Polyarticular Juvenile Idiopathic Arthritis (PJIA), Individual has had inadequate response to, is intolerant of, or has a medical contraindication to ONE Conventional therapy [non-biologic DMARD (such as methotrexate)] AND individual has had a trial and inadequate response or intolerance to: Humira(adalimumab) OR Enbrel(etanercept). For any of the above indications, if the TNF agent (Enbrel(etanercept)/Humira(adalimumab)) tried and failed are not acceptable due to concomitant clinical conditions, such as but not limited to any of the following: (a) Known hypersensitivity or any active or inactive component which is not also associated with Actemra (tocilizumab) or (b) Individual's age or (c) Pregnant or planning or becoming pregnant or (d) Serious infections or concurrent sepsis OR mbr has either concomitant clinical condition: (a) Demyelinating disease or (b) Heart failure with documented left ventricular dysfunction. For Multicentric Castleman Disease (MCD), agent is being used as a single agent for tx of relapsed/refractory or progressive MCD. Individual is HIV (human immunodeficiency virus) and HHV-8 (human herpes-8) negative. And individual has no concurrent clinically significant infection (for example, Hepatitis B or Hepatitis C) and has no concurrent lymphoma. For Giant Cell Arteritis, agent used in combination with a tapering course of corticosteroids (such as, prednisone) OR being used as a single agent after discontinuing corticosteroids. For chronic Antibody-mediated renal transplant rejection with the following are met (Choi 2017): mbr
	has chronic active antibody-mediated rejection plus donor-specific antibodies and transplant glomerulopathy AND has failed to respond to IVIG plus rituximab therapy with or without plasma exchange.
Indications	All Medically-accepted Indications.
Off Label Uses	

Actimmune

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Adcirca

Products Affected

- *alyq*
- *tadalafil (pah)*

PA Criteria	Criteria Details
Exclusion Criteria	Use in combination with phosphodiesterase-5 (PDE5) inhibitors [such as but not limited to, Cialis (tadalafil)] or use in combination with organic nitrates [such as but not limited to, isosorbide mono/dinitrate or nitroglycerin] or guanylate cyclase stimulators [such as but not limited to, Adempas (riociguat)]. For the treatment of benign prostatic hypertension or erectile dysfunction. Diagnosis of severe hepatic impairment (Child-Pugh Class C), pulmonary veno-occlusive disease (PVOD), severe renal impairment (creatinine clearance less than or equal to 30 mL/min) or on dialysis. Individual has a known degenerative retinal disorder (such as but not limited to, retinitis pigmentosa).
Required Medical Information	Catheterization-proven diagnosis of Pulmonary Arterial Hypertension World Health Organization (WHO) Group 1. Individual has WHO functional class II- IV symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Adempas

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	Use in combination with nitrates (such as but not limited to, nitroglycerin) or nitric oxide donors (such as but not limited to, amyl nitrite) in any form OR Use in combination with phosphodiesterase (PDE) inhibitors [such as, PDE-5 inhibitors (sildenafil, tadalafil, vardenafil) or nonspecific PDE inhibitors (dipyridamole, theophylline)]. Individual has a diagnosis of severe hepatic impairment (Child-Pugh class C). Individual is on dialysis or has creatinine clearance less than 15 ml/min. Individual has a diagnosis of pulmonary veno-occlusive disease (PVOD), or pulmonary hypertension associated with idiopathic interstitial pneumonias (PH-IIP).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has catheterization-proven diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 AND has WHO functional class II-IV symptoms. Or individual has catheterization-proven diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH), WHO Group 4 AND Individual has WHO functional class II-IV symptoms AND using for one of the following: Persistent or recurrent pulmonary hypertension after at least 180 days following surgical treatment with pulmonary endarterectomey OR Inoperable (via pulmonary endarterectomey) CTEPH.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	

AFINITOR

Products Affected

- AFINITOR
- AFINITOR DISPERZ
- *everolimus*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Alecensa

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Alimta

Products Affected

- ALIMTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Alpha1-Proteinase Inhibitor

Products Affected

- ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG
- GLASSIA
- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED
- ZEMAIRA

PA Criteria	Criteria Details
Exclusion Criteria	Alpha 1 proteinase inhibitors may not be approved for individuals with IgA antibodies.
Required Medical Information	Confirmed alpha-1 antitrypsin level is less than or equal to 11micro-mol/L (approximately equivalent to 80mg/dL measured by radial immunodiffusion or 57 mg/dL measured by nephelometry) (ATS/ERS 2003, Stoller 2017). Individual has clinically evident emphysema and one of the following: Moderate airflow obstruction is evidenced by forced expiratory volume (FEV1) of 30-65 percent of predicted value, prior to initiation of therapy OR a rapid decline in lung function as measured by a change in FEV1 greater than 120 ml/year.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Alunbrig

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Amphetamine Salts

Products Affected

- *amphetamine-dextroamphet er*
- *amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For dx ADHD, 3 years of age or older for immediate release. For Narcolepsy, 6 years of age or older for immediate release
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Ampyra

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	Individual has a history of seizures, OR moderate or severe renal impairment (defined as creatinine clearance less than or equal to 50 mL/min)
Required Medical Information	For renewal, individual achieved and sustained clinically significant improvement in ambulation related functional status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial approval 12 weeks, renewal 1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Anadrol 50

Products Affected

- ANADROL-50

PA Criteria	Criteria Details
Exclusion Criteria	Anadrol 50 may not be used to not replace other supportive measures for anemia such as transfusion, correction of iron, folic acid, B12 or pyridoxine deficiency, antibacterial therapy, or the appropriate use of corticosteroids. Using to enhance athletic ability. Individual has a diagnosis of Carcinoma of the prostate or breast in male individuals or Carcinoma of the breast in females with Hypercalcemia. Individual has a diagnosis of nephrosis (nephrotic phase of nephritis). Individual has a diagnosis of severe hepatic dysfunction.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Individual has a diagnosis of a deficient red cell production-associated anemia, such as but not limited to: acquired aplastic anemia, congenital aplastic anemia, myelofibrosis, or myelotoxic drug-associated hypoplastic anemia.
Indications	All Medically-accepted Indications.
Off Label Uses	

Apokyn

Products Affected

- APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE

PA Criteria	Criteria Details
Exclusion Criteria	Erectile Dysfunction (ED) use
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is using in conjunction with an antiemetic (excluding 5ht3 antagonist agents).
Indications	All Medically-accepted Indications.
Off Label Uses	

Arcalyst

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	Use in combination with other IL-1 inhibitors, JAK inhibitors, or other biologic drugs (such as IL-6 inhibitors, TNF antagonists, or selective co-stimulation modulators). Tuberculosis, other active serious infections or a history of recurrent infections. Individual has not had a tuberculin skin test (TST) or Centers for Disease Control (CDC)-recommended equivalent to evaluate for latent tuberculosis prior to initiating treatment with rilonacept.
Required Medical Information	
Age Restrictions	Individual is 12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

AUBAGIO

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other immunomodulatory agents (such as Gilenya, tecfidera, Tysabri, Copaxone, Extavia, Plegridy, Rebif, Avonex or Betaseron). Individual has an active acute or chronic infection at the initiation of therapy or has not had a tuberculin skin test (TST) or Centers for Disease Control (CDC)-recommended equivalent to evaluate for latent tuberculosis prior to initiation of therapy.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has been on Aubagio in the past 180 days OR individual has tried therapy with ONE of the following agents: Avonex (interferon beta-1a) OR Plegridy (interferon beta-1a) OR Betaseron (interferon beta-1b) OR Tecfidera (dimethyl fumarate) OR Copaxone/Glatopa (glatiramer).
Indications	All Medically-accepted Indications.
Off Label Uses	

Austedo

Products Affected

- AUSTEDO

PA Criteria	Criteria Details
Exclusion Criteria	Individual is suicidal or has untreated or inadequately treated depression. Individual has hepatic impairment. Individual is currently utilizing monoamine oxidase inhibitors (MAOIs), reserpine or tetrabenazine.
Required Medical Information	
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For initial requests, Individual has a diagnosis of chorea associated with Huntington's disease. Has a diagnosis of Tardive dyskinesia confirmed by the following DSM-5 AND (a.) At least 60 days of stable (drug, dose) medication exposure (either typical or first generation antipsychotic agents [such as, chlorpromazine, haloperidol, fluphenazine], atypical or second-generation antipsychotic agents [such as, clozapine, risperidone, olanzapine, quetiapine, aripiprazole], or certain dopamine receptor-blocking drugs used in treatment of nausea and gastroparesis [such as, prochlorperazine, promethazine, metoclopramide]) and (b.) Presence of involuntary athetoid or choreiform movements lasting at least 30 days. For continuation requests, Individual has experienced an improvement in symptoms deemed to be clinically significant by the provider (verbal attestation).
Indications	All Medically-accepted Indications.
Off Label Uses	

Balversa

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has confirmed (written or verbal attestation) disease susceptible to genetic alterations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Banzel

Products Affected

- BANZEL ORAL SUSPENSION
- BANZEL ORAL TABLET 200 MG, 400 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	1 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Baraclude

Products Affected

- BARACLUDE ORAL SOLUTION
- *entecavir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has a diagnosis of Chronic Hepatitis B virus (HBV) infection and has not been previously treated with lamivudine (AASLD 2016) OR is using as prophylaxis for hepatitis B reactivation in the setting of immune suppression (AGA 2015) or in combination with hepatitis C direct-acting antiviral therapy (AASLD 2017) OR Individual is a solid organ transplant recipient and using as prophylaxis for hepatitis B reactivation post (AASLD 2018).
Age Restrictions	2 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Bavencio

Products Affected

- BAVENCIO

PA Criteria	Criteria Details
Exclusion Criteria	Receiving treatment with another PD-1 agent (for example, Opdivo (nivolumab) or Keytruda (pembrolizumab)). Receiving therapy for an autoimmune disease or chronic condition requiring treatment with systemic immunosuppressant.
Required Medical Information	Current Eastern Cooperative Oncology Group (ECOG) performance status of 0-2 for metastatic merkel cell carcinoma and locally advanced or metastatic urothelial carcinoma.
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For metastatic merkel cell carcinoma, Bavencio is used when individual has not received treatment with another PD-1 (programed death receptor -1) agent (for example, Opdivo or Keytruda) and is not receiving treatment with a systemic immunosuppressant. For locally advanced or metastatic urothelial carcinoma, Bavencio is used as a single agent and individual has not received treatment with another PD-1 agent (for example, Opdivo or Keytruda) and is not receiving therapy for an autoimmune disease or chronic condition requiring treatment with a systemic immunosuppressant and individual meets ONE of the following criteria: has demonstrated disease progression on or after platinum-containing chemotherapy or has demonstrated disease progression within 12 months of receiving neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

Benlysta

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial treatment, individual has a Clinical diagnosis of SLE per the American College of Rheumatology [ACR] criteria AND Unequivocally positive ANA (anti-nuclear antibody) titer greater than or equal to 1:80 or anti-dsDNA (double stranded DNA antibody) greater than or equal to 30 IU/mL AND SLE is active as documented by a SELENA-SLEDAI score greater than or equal to 6 while on current treatment regimen AND There is no evidence of severe renal disease (proteinuria greater than 6 gm/day, serum creatinine greater than 2.5 mg/dl, or requiring renal dialysis) AND There is no evidence of active central nervous system lupus (e.g. psychosis and seizures) AND SLE remains active while on corticosteroid, antimalarials, and/or immunosuppressants for at least the last 30 days. For continuation of therapy, individual has a clinical diagnosis of SLE per the American College of Rheumatology [ACR] criteria AND documentation of previous improvement in disease activity following treatment with belimumab indicating a therapeutic response AND there is no evidence of severe renal disease AND there is no evidence of active central nervous system lupus.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Bosulif

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed (written or verbal attestation) BCR-ABL1 positive chronic phase disease. Individual has any of the following confirmed mutations (written or verbal attestation): E255K/V, F317L/V/I/C, F359V/C/I, T315A or Y253H.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has chronic myelogenous leukemia (CML) AND has newly-diagnosed Philadelphia-positive (Ph+) or confirmed(written or verbal attestation) BCR-ABL1 positive chronic phase disease OR is using in combination as primary treatment in lymphoid blast phase or myeloid blast phase disease OR using in post-allogenic HCT therapy for those with prior accelerated or blast phase disease with complete cytogenic response.
Indications	All Medically-accepted Indications.
Off Label Uses	

Braftovi

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Written or verbal attestation has been provided for either BRAF V600E or V600K genetic mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Briviact

Products Affected

- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Brukinsa

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has an ECOG 0-2 AND no prior BTK inhibitor usage
Age Restrictions	18 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Buphenyl

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Management of acute hyperammonemia
Required Medical Information	Using as adjunctive therapy for chronic management of hyperammonemia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Cabometyx

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Calquence

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Caprelsa

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Carbaglu

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Cayston

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	Individual has a forced expiratory volume in 1 second (FEV1) of less than 25% or greater than 75% of predicted
Required Medical Information	
Age Restrictions	7 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Celebrex

Products Affected

- *celecoxib oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE prescription Non-Steroidal Anti-Inflammatory Drugs (NSAID) or salicylates
Indications	All Medically-accepted Indications.
Off Label Uses	

Chantix

Products Affected

- CHANTIX CONTINUING MONTH PAK
- CHANTIX ORAL TABLET 0.5 MG, 1 MG
- CHANTIX STARTING MONTH PAK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Cholbam

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	Used to treat extrahepatic manifestations (such as but not limited to neurologic symptoms) of SED-associated-BASDs or PDs.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial therapy: 3 months. Continuation therapy: 1 year
Other Criteria	For initial therapy: (A) Diagnosis of bile acid synthesis disorders (BASDs) due to single enzyme defects (SEDs) including but not limited to 3 beta-hydroxy-delta 5-C27-steroid oxidotrductase defects OR (B) Diagnosis of peroximal disorders (PDs) including but not limited to Zellweger spectrum disorders AND (C) Individual has one of the following: (a) Manifestations of liver disease (for example, jaundice, hepatomegaly) (b) steatorrhea (c) Complications from decreased fat soluble vitamin (such as but not limited to vitamin D and K) absorption (for example, rickets, hypocalcemia, bleeding). For maintenance therapy: Meets the initial request criteria AND has had a clinical improvement (symptoms, lab values) in liver function and/or cholestasis AND has not developed a complete biliary obstruction.
Indications	All Medically-accepted Indications.
Off Label Uses	

Cimzia

Products Affected

- CIMZIA PREFILLED
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	Tuberculosis, invasive fungal infection, other active serious infections, or a history of recurrent infections prior to initiating Cimzia (certolizumab pegol). Individuals who have not had a tuberculin skin test or Center for Disease Control recommended equivalent to evaluate for latent tuberculosis prior to initiating Cimzia (certolizumab pegol). Using Cimzia in combination with other TNF antagonists, non-TNF immunomodulatory drugs: abatacept, anakinra, natalizumab, tofacitinib or rituximab.
Required Medical Information	Individual has chronic moderate to severe (that is, extensive or disabling) plaque psoriasis with either of the following: Individual has greater than 5% of body surface area with plaque psoriasis OR less than or equal to 5% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For moderate to severe Crohn's Disease, Individual has had an inadequate response to, is intolerant of, or has a medical contraindication to ONE conventional therapy (e.g. 5-ASA products, systemic corticosteroids, or immunosuppressants) AND Individual has had trial and inadequate response or is intolerant to Humira (adalimumab). For moderate to severe Rheumatoid Arthritis, Individual has had an inadequate response to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARD AND Individual has had a trial and an inadequate response or is intolerant to Humira (adalimumab) OR Enbrel (etanercept). For moderate to severe Psoriatic Arthritis, Individual has had an inadequate response to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as nonbiologic DMARDs) AND has had a trial and an inadequate response or is intolerant to Humira (adalimumab) OR Enbrel (etanercept). For moderate to severe Ankylosing Spondylitis (AS), Individual has had an inadequate response to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as NSAIDs or non-biologic DMARDs) AND has had a trail and an inadequate response or is intolerant to Humira (adalimumab) OR Enbrel (etanercept). For plaque psoriasis individual has had an inadequate response to, is intolerant of, or has a contraindication to phototherapy or other systemic therapy (such as acitretin, cyclosporine, or methotrexate) AND has had a trial of and inadequate response or intolerance to Humira (adalimumab) OR Enbrel (etanercept). For any of the above indications, if the TNF agent (Enbrel/Humira) tried and failed are not acceptable due to concomitant clinical conditions, such as but not limited to any of the following: (a) Known hypersensitivity or any active or inactive component which is not also associated with Cimzia or (b) Individual's age or (c) Pregnant or planning or becoming pregnant or (d) Serious infections or concurrent sepsis OR individual has either concomitant clinical condition: (1) Demyelinating disease or (2) Heart failure with documented left ventricular dysfunction. For non-radiographic axial spondyloarthritis, individual has had an
	inadequate response to, or has a contraindication to conventional therapy [such as NSAID or nonbiologic such as sulfasalazine)].
Indications	All Medically-accepted Indications.
Off Label Uses	

Cometriq

Products Affected

- COMETRIQ (100 MG DAILY DOSE)
- COMETRIQ (140 MG DAILY DOSE)
- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Copaxone

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Individual with primary progressive MS (PPMS). Individual with secondary progressive MS (SPMS) without relapsing disease. Concurrent use with other MS Disease modifying agents (such as, Aubagio, Gilenya, Tecfidera, Tysabri, Lemtrada, Ocrevus, Copaxone/Glatopa, Extavia, Rebif, Avonex, Plegridy or Betaseron).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Copiktra

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Corlanor

Products Affected

- CORLANOR ORAL SOLUTION
- CORLANOR ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Individual has a heart rate maintained exclusively by a pacemaker. Individual has clinically significant hypotension. Individual has severe hepatic impairment (Child-Pugh Class C).
Required Medical Information	
Age Restrictions	For NYHA Class II, II, or IV due to DCM, age 6 months or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	(A) Individual is using for the treatment of New York Heart Association (NYHA) class II, III or IV heart failure symptoms AND has a left ventricular ejection fraction less than or equal to 35% AND will be utilizing in combination with a beta-blocker OR has a contraindication or intolerance to beta-blocker therapy AND is in normal sinus rhythm AND If initiating treatment with Corlanor, individual has a resting heart rate greater than or equal to 70 beats per minute. OR (B) Individual is using for the treatment of New York Heart Association (NYHA) class II, III, or IV heart failure symptoms due to dilated cardiomyopathy AND has a left ventricular ejection fraction less than or equal to 45% AND is in normal sinus rhythm AND If initiating treatment with Corlanor, individual has an elevated resting heart rate.
Indications	All Medically-accepted Indications.
Off Label Uses	

Cosentyx

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Using Cosentyx in combination with other IL17 inhibitors or biologic drugs. Using in combination with phototherapy. Individuals with tuberculosis, other active serious infections or a history of recurrent infections. Individual has not had a tuberculin skin test (TST) or a Centers of Disease Control and Prevention (CDC)-recommended equivalent test to evaluate for latent tuberculosis prior to initiating Cosentyx
Required Medical Information	Individual has moderate to severe plaque psoriasis with either of the following: Individual has greater than 5% of body surface area with plaque psoriasis OR Less than or equal to 5% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For moderate to severe Ankylosing Spondylitis (AS), individual had an inadequate response to/intolerant of or has a medical contraindication to ONE conventional therapy [such as, NSAIDs or nonbiologic DMARDS such as sulfasalazine or a tumor necrosis factor (TNF) antagonist] AND Individual has had a trial of/inadequate response or is intolerant to Enbrel (etanercept) OR Humira (adalimumab). For moderate to severe plaque psoriasis (Ps), individual had an inadequate response to/intolerant of or has contraindication to phototherapy or other systemic therapy (such as acitretin, cyclosporine or methotrexate) AND Individual has had a trial of/inadequate response or is intolerant to Enbrel (etanercept) OR Humira (adalimumab). For moderate to severe Psoriatic Arthritis (PsA), individual has had an inadequate response to/intolerant of or has a medical contraindication to conventional therapy [nonbiologic DMARDs (such as methotrexate, sulfasalazine or leflunomide)] or TNF antagonist (AAD 2011) AND Individual has had a trial of and an inadequate response or is intolerant to Enbrel (etanercept) OR Humira (adalimumab). For any of the above indications, if the TNF agent (Enbrel(etanercept)/Humira (adalimumab)) tried and failed are not acceptable due to concomitant clinical conditions, such as but not limited to any of the following: (a) Known hypersensitivity or any active or inactive component which is not also associated with Cosentyx or (b) Individual's age or (c) Pregnant or planning or becoming pregnant or (d) Serious infections or concurrent sepsis OR individual has either concomitant clinical condition: (a) Demyelinating disease or (b) Heart failure with documented left ventricular dysfunction, Cosentyx may be allowed without trial of preferred TNF agents (Enbrel/Humira).
Indications	All Medically-accepted Indications.
Off Label Uses	

Cotellic

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of unresectable or metastatic melanoma with confirmed (written or verbal attestation) BRAF V600E or V600K mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is using Cotellic (cobimetinib) in combination with Zelboraf (vemurafenib).
Indications	All Medically-accepted Indications.
Off Label Uses	

Cyramza

Products Affected

- CYRAMZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For urothelial cancer, an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1.
Age Restrictions	For urothelial cancer, 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	For locally advanced, unresectable or metastatic urothelial cancer originating from bladder, urethra, ureter or renal pelvis and using in combination with docetaxel AND disease has progressed after platinum-containing chemotherapy (cisplatin or carboplatin) AND individual has received treatment with no more than one immune checkpoint inhibitor (such as, atezolizumab, avelumab, durvalumab, nivolumab or pembrolizumab) AND has received treatment with no more than one prior systemic chemotherapy regimen in the relapsed or metastatic setting AND individual has not received prior systemic taxane therapy in any setting (neoadjuvant, adjuvant or metastatic).
Indications	All Medically-accepted Indications.
Off Label Uses	

Daliresp

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Exclusion Criteria	Individual is using to treat acute bronchospasm OR moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment OR using concomitantly with strong cytochrome P450 enzyme inducer (such as but not limited to phenobarbital, carbamazepine or phenytoin)
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is currently or will be concomitantly using with a long-acting bronchodilator.
Indications	All Medically-accepted Indications.
Off Label Uses	

Darzalex

Products Affected

- DARZALEX INTRAVENOUS SOLUTION 400 MG/20ML

PA Criteria	Criteria Details
Exclusion Criteria	Has received treatment with daratumumab or another anti-CD38 agent
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Daurismo

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 75 years old or older OR has comorbidities that preclude use of intensive induction chemotherapy.
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Desoxyn

Products Affected

- *methamphetamine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	Adjunct treatment of exogenous obesity/weight loss.
Required Medical Information	
Age Restrictions	Individual is 6 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of attention deficit hyperactivity disorder (ADHD) AND has had an appropriate trial of one of the following: (a) methylphenidate containing agent OR (b) amphetamine containing agent (such as, amphetamine/dextroamphetamine, lisdexamfetamine, or dextroamphetamine).
Indications	All Medically-accepted Indications.
Off Label Uses	

Duavee

Products Affected

- DUAVEE

PA Criteria	Criteria Details
Exclusion Criteria	May not be approved for the following: (1) If individual had a hysterectomy (2) Individual has undiagnosed abnormal uterine bleeding (3) Individual has known, suspected, or past history of breast cancer (4) Individual has known or suspected estrogen-dependent neoplasia (5) Individual has active or past history of venous thromboembolism (6) Individual has active or past history of arterial thromboembolism (7) Individual has known hepatic impairment or disease OR (8) Individual has known protein C, protein S, or antithrombin deficiency or other known thrombophilic disorders.
Required Medical Information	
Age Restrictions	Age 18 through age 75
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is using for ONE of the following: Treatment of moderate to severe vasomotor symptoms associated with menopause OR Individual is using for prevention of postmenopausal osteoporosis AND is using solely for prevention of osteoporosis and has had a trial of and inadequate response or intolerance or has a contraindication to non-estrogen agents for osteoporosis.
Indications	All Medically-accepted Indications.
Off Label Uses	

Duopa

Products Affected

- DUOPA ENTERAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For advanced Parkinsons disease with complicated motor fluctuations that have not been adequately controlled with optimal medical therapy with any TWO of the following: Oral levodopa-carbidopa, a Dopamine agonist [such as, but limited to Apokyn (apomorphine), Mirapex (pramipexole), Requip (ropinirole) and Neupro (rotigotine)], a catechol-0-methyl transferase (COMT) inhibitor [such as, but not limited to Comtan (entacapone) and Tasmar (tolcapone)], or a monoamine oxidase B (MAO)-B inhibitor [such as, but not limited to Eldepryl (selegiline), and Azilect (rasagiline)].
Indications	All Medically-accepted Indications.
Off Label Uses	

Duragesic Patch

Products Affected

- *fentanyl*

PA Criteria	Criteria Details
Exclusion Criteria	Individual is requesting or using as an as-needed analgesic OR Individual has one of the following conditions: (a) Significant respiratory depression OR (b) Acute or severe bronchial asthma or hypercarbia OR (c) Known or suspected paralytic ileus.
Required Medical Information	
Age Restrictions	Individual is 2 years of age or older
Prescriber Restrictions	
Coverage Duration	Initial 3 months. Maintenance 6 months. Cancer Pain/Terminal Dx or Palliative Care 1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use, Individual has one of the following: (a) Diagnosis of cancer related pain and/or is actively undergoing cancer therapy (provide cancer diagnosis) OR (b) Diagnosis of terminal illness and is receiving palliative/end-of-life care (provide terminal diagnosis) OR Individual has pain severe enough to require daily, around-the-clock, long term opioid treatment (provide diagnosis) AND Individual has one of the following: (a) An inadequate response to ONE alternative treatment options, such as but not limited to non-opioid analgesics and immediate-release opioids OR (b) Alternative treatment options would otherwise be inadequate to provide sufficient management of pain OR (c) Individual has contraindications to non-opioid analgesics (such as NSAID use in individuals with active ulcer condition/gastrointestinal bleeding, renal failure) AND Individual is not opioid naïve as noted by the following: (a) Individual is currently using a short-acting opioid analgesic, including use of opioid analgesia as an inpatient for post-surgical pain OR (b) Individual is transitioning from one long-acting opioid analgesic to another long-acting opioid analgesic OR (c) already receiving at least 60 mg/day of oral morphine, 30 mg/day of oral oxycodone, 8 mg/day of oral hydromorphone, or an equianalgesic dose of another opioid. For continued use, Attestation (verbal or written) that long-acting opioid therapy has provided meaningful improvement in pain and/or function compared to baseline AND prescriber has consulted with individual regarding risks of opioid therapy AND clear treatment goals have been defined and outlined as part of overall pain.
Indications	All Medically-accepted Indications.
Off Label Uses	

Egrifta

Products Affected

- EGRIFTA SUBCUTANEOUS SOLUTION RECONSTITUTED 1 MG
- EGRIFTA SV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial requests, individual has a body mass index (BMI) is greater than 20 kg/m2 AND waist circumference and a waist-to-hip ratio of one of the following (Falutz 2010): (a) For males, waist circumference greater than or equal to 95cm and waist-to-hip ratio greater than or equal to 0.94 OR (b) For females, waist circumference greater than or equal to 94cm and waist-to-hip ratio greater than or equal to 0.88 AND fasting blood glucose (FBG) is less than 150 mg/dL (8.33 mmol/L) AND no history of type 1 diabetes or insulin-treated type 2 diabetes AND no active malignancy (e.g., a potential cancer which is being evaluated or a diagnosed cancer which is being treated). For continuation, individual must demonstrate there is a clear response in reduction of visceral adipose tissue measured by waist circumference or computed tomography (CT) scan.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Initial 6 months, renewal 1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Elidel

Products Affected

- *pimecrolimus*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 2 years of age and older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual had a trial of and inadequate response or intolerance to one topical prescription strength corticosteroid.
Indications	All Medically-accepted Indications.
Off Label Uses	

ELIGARD_GNRH

Products Affected

- ELIGARD SUBCUTANEOUS KIT 22.5 MG, 7.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7/Gleason grade group 2-3, or prostate specific antigen (PSA) value of 10-20 ng/mL) OR higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR Other advanced, recurrent, or metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Emgality

Products Affected

- EMGALITY
- EMGALITY (300 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 3 months, Maintenance: 1 Year

PA Criteria	Criteria Details
Other Criteria	For Initial requests: (I) Individual has a diagnosis of one of the following: (a) Episodic migraine defined as at least 4 and fewer than 15 migraine days per month and fewer than 15 headache days per month on average during the previous 3 month period OR (b) Chronic migraine defined as headache occurring on 15 or more days per month for more than 3 months, which on at least 8 days per month, has features of a migraine headache (ICHD-3) AND (c) Individual is using for migraine prophylaxis OR (II) Individual is using for tx of episodic cluster headaches. (III) Individual has dx of cluster headaches meeting the following IHS diagnostic criteria (ICHD3): (a) Individual has 5 or more headache attacks AND (b) has severe or very severe unilateral orbital supraorbital and/or temporal pain lasting 15 to 180 minutes if untreated AND (c) Headache accompanied by 1 or both of the following: (i) 1 or more of following sx or signs, ipsilateral to the headache: (1) Conjunctival injection and/or lacrimation (2) nasal congestion and/or rhinorrhea (3) eyelid edema (4) forehead and facial sweating or (5) miosis and/or ptosis OR (ii) sense of restlessness or agitation AND (d) Attacks have frequency from 1 every other day to 8/day AND (e) Headache is not attributed to another headache disorder AND (IV) Cluster headaches are episodic per following diagnostic criteria (ICHD-3 Beta): (a) Individual has cluster headache attacks that occur in bouts (cluster periods) AND (b) Individual has at least 2 cluster periods lasting from 7 days to 1 year (when untreated) and separated by pain-free remission periods of greater than or equal to 3 months. For Renewal requests: Individual has a reduction in the overall number of migraine days or reduction in number of severe migraine days per month AND Individual has obtained clinical benefit deemed significant by individual or prescriber.
Indications	All Medically-accepted Indications.
Off Label Uses	

Emsam

Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	Individuals with pheochromocytoma OR Individual is currently taking one of the following: (1) Selective serotonin reuptake inhibitors (SSRIs) (for example, fluoxetine) OR (2) Serotonin and norepinephrine reuptake inhibitors (SNRIs) (for example, venlafaxine) OR (3) Tricyclic antidepressants (clomipramine or imipramine) OR (4) Opiate analgesics (meperidine, tramadol, methadone, pentazocine) OR (5) Dextromethorphan OR (6) Carbamazepine.
Required Medical Information	Individual has no known contraindications to the use of a monoamine oxidase inhibitor (MAOI).
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Enbrel

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML
- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	Entanercept used in combination with other TNF antagonist JAK inhibitors, other biologic drugs (such as, abatacept, anakinra, vedolizumab), or cyclophosphamides. Tuberculosis, other active serious infections or history of recurrent infections. Individual who have not had a tuberculin skin test or a CDC-recommended equivalent to evaluate for latent tuberculosis prior to initiating etanercept.
Required Medical Information	For chronic moderate to severe plaque psoriasis with either of the following: Individual has greater than 5% of body surface area with plaque psoriasis OR Less than or equal to 5% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	Individual is 18 years of age or older, except for the diagnosis of JIA and plaque psoriasis. For JIA individual is 2 years of age or older. For plaque psoriasis, 4 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year except for Initial high dose tx chronic plaque psoriasis 12 wk

PA Criteria	Criteria Details
Other Criteria	For moderate to severe Ankylosing Spondylitis, individual has had an inadequate response to, is intolerant of, or has a contraindication to ONE conventional therapies: (such as NSAIDs or nonbiologic DMARDs) (ACR 2015). For Moderate to severe Chronic Plaque Psoriasis, individual has had inadequate response to, is intolerant of, or has a medical contraindication to phototherapy OR ONE other systemic therapies (such as, methotrexate, acitretin, or cyclosporine). For moderate to severe Rheumatoid Arthritis, individual has had an inadequate response to, is intolerant of, or has a contraindication to ONE conventional therapy [nonbiologic DMARDs (such as methotrexate, sulfasalazine, leflunomide or hydroxychloroquine)] (ACR 2015). For moderate to severe Polyarticular JIA, individual has had an inadequate response to, is intolerant of, or has a contraindication to ONE conventional therapy [nonbiologic DMARDs such as methotrexate] (ACR 2011). For moderate to severe Psoriatic Arthritis, individual has had an inadequate response to, is intolerant of, or has a contraindication to ONE conventional therapy [nonbiologic DMARDs (such as methotrexate, sulfasalazine or leflunomide)] (AAD 2011).
Indications	All Medically-accepted Indications.
Off Label Uses	

Entresto

Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Exclusion Criteria	Individual is pregnant/ wishing to become pregnant OR breastfeeding OR has a history of angioedema related to previous ACE inhibitor or ARB therapy OR has severe hepatic impairment (Child-Pugh C). OR Individual will be utilizing an angiotensin-converting enzyme (ACE) inhibitor OR angiotensin receptor blocker (ARB) in combination with Entresto (sacubitril/valsartan). Individual will be utilizing Entresto (sacubitril/valsartan) in combination with Tekturna (aliskiren)/Tekturna HCT (aliskiren/hydrochlorothiazide) and has a diagnosis of diabetes or renal impairment (eGFR less than 60 mL/min/1.73 m2).
Required Medical Information	Individual has a left ventricular ejection fraction less than or equal to 40%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Epclusa

Products Affected

- SOFOSBUVIR-VELPATASVIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes genotype and positive HCV RNA result (AASLD/IDSA 2017, CDC 2013) AND Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy AND Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2016).
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	

Epidiolex

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	2 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Epogen and Procrit

Products Affected

- RETACRIT

PA Criteria	Criteria Details
Exclusion Criteria	Anemia in patients due to other factors such as iron deficiency, folate deficiency or B12 deficiency, hemolysis, gastrointestinal bleeding, other active or occult bleeding, or underlying hematologic diseases (such as sickle cell anemia, thalassemia, and porphyria). Sudden loss of response with severe anemia and low reticulocyte count. Treatment of anemia in patients with cancer not treated by chemotherapy known to produce anemia. Treatment of in any indication not listed in criteria including anemia of prematurity. Anemia in cancer patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure. Anemia in cancer patients receiving hormonal agents, therapeutic biologic products, or radiotherapy unless receiving concomitant myelosuppressive chemotherapy. Anemia in cancer patients receiving myelosuppressive chemotherapy in whom the anemia can be managed by transfusion. Continued use when the hemoglobin level exceeds 11.0 g/dL unless otherwise specified in the criteria. Use beyond 12 weeks in the absence of response in individuals with chronic renal failure. Use beyond 8 weeks in the absence of response in individuals with myelodysplastic syndrome (MDS). Use beyond 8-9 weeks in the absence of response or if transfusions are still required in individuals with metastatic, non-myeloid cancer being treated with myelosuppressive chemotherapy agents known to produce anemia. Continued use beyond 6 weeks after therapy with myelosuppressive chemotherapy known to produce anemia is completed. Pre-operative use for patients who are willing to donate autologous blood.

PA Criteria	Criteria Details
Required Medical Information	Hemoglobin (Hgb) levels are less than 10.0 g/dL, prior to initiation of therapy (unless otherwise specified) AND prior to initiation of therapy, (baseline) evaluation of the individual iron status reveals, transferrin saturation at least 20% or ferritin at least 80 ng/mL or bone marrow demonstrates adequate iron stores AND For individuals with uncontrolled hypertension, blood pressure is adequately controlled before initiation of therapy and closely monitored and controlled during therapy. For MDS, endogenous erythropoietin level is less than 500 mU/ml. For anemia related to zidovudine in HIV-infected patients when the dose of zidovudine is less than or equal to 4200 mg per week, endogenous erythropoietin level is less than or equal 500 mU/ml. Reduction of Allogeneic Blood Transfusion in Pre-Operative Surgery Patients: Patient's hgb is greater than 10.0 and less than or equal to 13.0 g/dL, individual is scheduled to undergo elective, noncardiac, nonvascular surgery, individual is at high risk for perioperative transfusions with significant, anticipated blood loss, individual is unable or unwilling to donate autologous blood, Antithrombotic prophylaxis has been considered. For tx of anemia due to myelosuppressive chemotherapy known to produce anemia when the following are met: chemo is planned for a minimum of 2 months and the dx is non-myeloid cancer and the anticipated outcome is not cure. For anemia associated with CKD ON dialysis use is to achieve and maintain hgb levels within the range of 10.0 to 11.0 g/dL. For anemia associated with CKD NOT ON dialysis use is to achieve and maintain hgb levels of 10.0g/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	8wk.
Other Criteria	For Hepatitis C, patient is concomitantly treated with combination of ribavirin and interferon alfa, or ribavirin and peginterferon alfa. Myelosuppressive drugs known to produce anemia in individuals with a diagnosis of chronic inflammatory disease. Allogeneic bone marrow transplantation.
Indications	All Medically-accepted Indications.
Off Label Uses	

Eraxis

Products Affected

- ERAXIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Erivedge

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Erleada

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Esbriet

Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG

PA Criteria	Criteria Details
Exclusion Criteria	Individuals using in combination with Ofev (nintedanib). Individuals with end-stage renal disease (ESRD). Individuals with severe hepatic impairment (child pugh class C) or end-stage liver disease.
Required Medical Information	Diagnosis of idiopathic pulmonary fibrosis (IPF) is confirmed by: Exclusion of other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity AND High resolution computed tomography (HRCT) with or without surgical lung biopsy. Individual has documented pulmonary function tests within prior 60 days with a Forced Vital Capacity (% FVC) greater than or equal to 50%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Exjade

Products Affected

- *deferasirox oral tablet soluble*
- EXJADE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 2 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Farydak

Products Affected

- FARYDAK ORAL CAPSULE 10 MG, 15 MG, 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Fentora

Products Affected

- *fentanyl citrate buccal tablet*

PA Criteria	Criteria Details
Exclusion Criteria	Using for treatment of acute or postoperative pain OR migraine headache pain OR non-cancer related pain.
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of active cancer (such as, metastatic or locally invasive cancer for which the individual is currently seeking treatment) with breakthrough cancer pain (provide diagnosis) AND has tried and failed fentanyl citrate lozenge (generic Actiq) AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving around the clock medicine consisting of one of the following: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR At least 25mg of oral oxymorphone daily, OR An equianalgesic dose of another opioid for a week or longer. Individual will also continue around the clock opioids when taking fentanyl citrate for cancer related breakthrough pain.
Indications	All Medically-accepted Indications.
Off Label Uses	

Ferriprox

Products Affected

- FERRIPROX ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Fetzima

Products Affected

- FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG
- FETZIMA TITRATION

PA Criteria	Criteria Details
Exclusion Criteria	May not be approved for treatment of fibromyalgia
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For MDD, individual has had a trial of TWO of the following: Desvenlafaxine ER, desvenlafaxine Fumerate ER, fluoxetine, fluvoxamine, escitalopram, citalopram, paroxetine, sertraline, mirtazapine, immediate-release venlafaxine, extended-release venlafaxine or bupropion.
Indications	All Medically-accepted Indications.
Off Label Uses	

Firazyr

Products Affected

- FIRAZYR
- *icatibant acetate*

PA Criteria	Criteria Details
Exclusion Criteria	Prophylaxis for HAE attacks.
Required Medical Information	HAE to be confirmed by a C4 level below the lower limit of normal (as defined by the laboratory performing the test) and either a C1 inhibitor antigenic level below the lower limit of normal (as defined by the lab performing test) or a C1 inhibitor functional level below the lower limit of normal (as defined by the lab performing the test).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has a history of moderate or severe attacks (for example, airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion) and using Icatibant for acute HAE attacks.
Indications	All Medically-accepted Indications.
Off Label Uses	

Firmagon

Products Affected

- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7/Gleason grade group 2-3, or prostate specific antigen (PSA) value of 10-20 ng/mL) OR higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR Used for progressive castration-naïve disease or for castration-recurrent disease OR Other advanced, recurrent, or metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Forteo

Products Affected

- FORTEO SUBCUTANEOUS SOLUTION 600 MCG/2.4ML

PA Criteria	Criteria Details
Exclusion Criteria	Individual is using Forteo (teriparatide) in combination with any of the following: Prolia (denosumab), Bisphosphonates, Evista (raloxifene), Miacalcin/Fortical (calcitonin nasal spray), Recalst (zolendronic acid), or Tymlos (abalaoparatide).
Required Medical Information	Osteoporosis is defined as a BMD T-Score in the spine, femoral neck, total hip or distal 1/3 of the radius of less than or equal to -2.5 as compared to young adult reference population OR a Clinical diagnosis based on a history of a low trauma fracture (fragility fracture) at high risk for fracture OR associated with sustained systemic glucocorticoid therapy (daily dosage equivalent to 5mg or greater of prednisone for at least 3 months) at high risk for fracture.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 years. Requests to continue therapy beyond 24 months (2 years) should not be approved.
Other Criteria	Individual meets one of the following: (A) Individual has been refractory to a trial of an oral bisphosphonate therapy OR (B) Intolerance or contraindications to oral bisphosphonate as defined by having at least one of the following: 1. Hypersensitivity to TWO oral bisphosphonates (one of which must be alendronate) 2. Inability to sit or stand upright for at least 30 minutes, 3. Pre-existing gastrointestinal disorders (Barrett's esophagus, hypersecretory disorders, delayed esophageal emptying, etc.). 4. Uncorrected hypocalcemia. 5. Severe renal insufficiency as defined by creatinine clearance less than 35 mL/min for alendronate agents or creatinine clearance less than 30 mL/min for risedronate and ibandronate.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	

Gattex

Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For diagnosis of Short Bowel Syndrome (SBS) individual has been dependent on parenteral nutrition/intravenous (PN/IV) support, For at least 12 months AND requires PN at least 3 times per week.
Indications	All Medically-accepted Indications.
Off Label Uses	

Gazyva

Products Affected

- GAZYVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	Gazyva may be approved for treatment of chronic lymphocytic leukemia/small lymphocytic lymphoma for any of the following: a) first-line in individuals without del (17p) mutation when used in combination with chlorambucil or bendamustine OR as first-line single agent in individuals who are frail or with del (17p) mutation OR as a single agent for the treatment of relapsed/refractory disease without del (17p) mutation. Approved for the treatment of follicular lymphoma when used as a component of ONE of the following combination therapies regimens and as monotherapy for up to 24 months or until disease progression, following the listed combination therapy regimens: cyclophosphamide, doxorubicin, vincristine and prednisone (CHOP regimen) or cyclophosphamide, vincristine, and prednisone (CVP regimen) or bendamustine.
Indications	All Medically-accepted Indications.
Off Label Uses	

Gilenya

Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other MS disease modifying agents (such as, Aubagio, Tecfidera, Tysabri, Ocrevus, Copaxone/Glotopa, Extavia, Rebif, Avonex, Plegridy, Betaseron). Individual has history or presence of Mobitz Type II second- or third-degree atrioventricular (AV) block or sick sinus syndrome, unless individual has a functioning pacemaker. Individual has a baseline QTc interval greater than or equal to 500 ms. Individual is being treated with Class Ia (such as quinidine, procainamide, or disopyramide) or Class III [such as amiodarone, Multaq (dronedarone), Tikosyn (dofetilide), or sotalol] anti-arrhythmic drugs. Individual has had a recent (within the past 6 months) occurrence of one of the following: Myocardial infarction, Unstable angina, Stroke, Transient ischemic attack (TIA), Decompensated heart failure requiring hospitalization, Class III/IV heart failure or individual has an active acute or chronic infection at the initiation of therapy.
Required Medical Information	I. Individual has had a trial and inadequate response or intolerance to one of the following: Avonex (interferon beta-1a), Plegridy (interferon beta-1-a), Betaseron (interferon beta-1b), Tecfidera (dimethyl fumarate), Copaxone/Glatopa (glatiramer) OR II. Individual has high disease activity despite treatment with a disease modifying drug (Aubagio, Avonex, Plegridy, Rebif, Betaseron, Extavia, Copaxone/Glatopa, Tecfidera) defined as the following: At least 1 relapse in the previous year while on therapy AND At least 9 T2-hyperintense lesions in cranial MRI OR At least 1 Gadolinium-enhancing lesion. OR III. Individual is treatment naive (no previous history of use of disease modifying drugs such as Aubagio, Avonex, Plegridy, Rebif, Betaseron, Extavia, Copaxone/Glatopa, Tecfidera) AND IV. Individual has rapidly evolving severe relapsing multiple sclerosis defined as the following: Two or more disabling relapses in 1 year AND One or more Gadolinium-enhancing lesions on brain MRI.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Gilotrif

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Test results confirmed for individuals with metastatic non-small cell lung cancer (NSCLC) with non-resistant epidermal growth factor receptor (EGFR) mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Gleevec

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Gleostine

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Granix

Products Affected

- GRANIX SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	Use as prophylaxis for FN during concomitant chemotherapy and radiation therapy. Continued use if no response is seen within 28-42 days (individuals who have failed to respond within this time frame are considered non-responders).
Required Medical Information	Primary prophylaxis of FN in Individual that has a risk of developing FN is greater than or equal to 10% and less than of 20% based on chemotherapy regimens and individuals have any of the following risk factors for FN: Individual age greater than 65 years, Poor performance status, Bone marrow involvement by tumor producing cytopenias, persistent neutropenia (ANC less than 1500mm3), poor renal function (GFR less than 60mL/min), liver dysfunction, recent surgery and/or presence of open wounds. Individual has not received prophylactic therapy with granulocyte colongy stimulating factor AND has a high-risk for infection associated complications as demonstrated by any of the following: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10to the power of 9/L) neutropenia, Age greater than 65 years, Pneumonia or other clinically documented infections, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, prior episode of febrile neutropenia or Hospitalized at the time of the development of fever.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has trial and inadequate response to Zarxio (filgrastim-sndz). Individual is using to mobilize progenitor cells into peripheral blood for collection by leukapheresis as adjunct to peripheral blood/hematopoietic stem cell transplantation (PBSCT/PHSCT).

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

Haegarda

Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Hereditary angioedema (HAE) is confirmed by a C4 level below the lower limit of normal as defined by the laboratory performing the test AND ANY of the following (a, b, or c): (a) C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test or (b) C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test or (c) Presence of a known HAE-causing C1-INH mutation.
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has a history of moderate or severe attacks and is using Haegarda as prophylaxis for short-term use prior to surgery, dental procedures or intubation OR for long-term prophylaxis and individual has failed, or is intolerant to, or has contraindication to 17-alpha-alkylated androgens or antifibrinolytic agents.
Indications	All Medically-accepted Indications.
Off Label Uses	

Harvoni

Products Affected

- LEDIPASVIR-SOFOSBUVIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation is provided for a diagnosis of chronic Hepatitis C virus (CHC) infection, which includes Genotype and a positive HCV RNA result (AASLD/IDSA 2017, CDC 2013) AND Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy AND Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2016).
Age Restrictions	12 years of age or older.
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	

Hepsera

Products Affected

- *adefovir dipivoxil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	12 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has had a previous trial and inadequate response or intolerance to or has a contraindication to an alternative antiviral agent with a higher genetic barrier to resistance for Hepatitis B [such as entecavir or tenofovir] (AASLD 2016).
Indications	All Medically-accepted Indications.
Off Label Uses	

Hetlioz

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

HP Acthar

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	All other uses except those listed under Other Criteria section.
Required Medical Information	
Age Restrictions	For West Syndrome, infant or child less than 2 years of age.
Prescriber Restrictions	
Coverage Duration	6 month
Other Criteria	Individual is using for infantile spasm (West Syndrome).
Indications	Some FDA-approved Indications Only.
Off Label Uses	

HRM Age

Products Affected

- *amitriptyline hcl oral*
- *amoxapine*
- *chlordiazepoxide-amitriptyline*
- *clomipramine hcl oral*
- *desipramine hcl oral*
- *doxepin hcl oral capsule*
- *doxepin hcl oral concentrate*
- *imipramine hcl oral*
- *imipramine pamoate*
- *nortriptyline hcl oral*
- *perphenazine-amitriptyline*
- *phenobarbital oral elixir*
- *phenobarbital oral solution*
- *phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg*
- *protriptyline hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

HRM Age AU

Products Affected

- *benztropine mesylate oral*
- BUTISOL SODIUM ORAL TABLET 30 MG
- *carbinoxamine maleate oral solution*
- *carbinoxamine maleate oral tablet 4 mg*
- *chlorzoxazone oral tablet 500 mg*
- *clemastine fumarate oral tablet 2.68 mg*
- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*
- *cyproheptadine hcl oral*
- *digitek oral tablet 250 mcg*
- *digox oral tablet 250 mcg*
- *digoxin oral tablet 250 mcg*
- *disopyramide phosphate oral*
- *ergoloid mesylates oral*
- *estradiol oral*
- *estradiol transdermal patch twice weekly*
- *hydroxyzine hcl oral tablet 25 mg, 50 mg*
- *ketorolac tromethamine oral*
- *megestrol acetate oral suspension 625 mg/5ml*
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- *meprobamate*
- *metaxalone*
- *orphenadrine citrate er*
- *phenadoz*
- PREMARIN ORAL
- PREMPHASE
- PREMPRO
- *promethazine hcl oral*
- *promethazine hcl rectal suppository 12.5 mg, 25 mg*
- *promethegan*
- *trihexyphenidyl hcl*
- *zolpidem tartrate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	

Human Growth Hormone

Products Affected

- NORDITROPIN FLEXPRO
- OMNITROPE

PA Criteria	Criteria Details
Exclusion Criteria	Use of GH tx when applicable criteria have not been met may not be approved for, but not limited to, the following: Renal transplant, Anabolic tx, except for AIDS, provided to counteract acute or chronic catabolic illness (e.g. surgery, trauma, cancer,chronic hemodialysis) producing catabolic (protein wasting) changes in both adult and ped. Anabolic tx to enhance body mass or strength for professional, recreational or social reasons, Constitutional delay of growth and development. Cystic fibrosis, GH Tx in combo with GnRH agonist (Lupron-leuprolide) as a Tx of precocious puberty. Hypophosphatemic rickets, osteogenesis imperfecta, osteoporosis, Short Stature associated with GH insensitivity (Laron Syndrome). Therapy in older adults with normally occurring decrease in GH, who are not congenitally GH deficient and who have no evidence of organic pituitary dz (this is referred to as age-related GH deficiency). Tx of CHF, burn patients, fibromyalgia, glucocorticoid-induced growth failure. Tx of HIV lipodystrophy (fat redistribution syndrome), also referred to as altered body habitus (e.g. buffalo hump), associated with antiviral therapy in HIV-infected patients. Tx of intrauterine growth restriction (IUGR)or Russell-Silver Syndrome that does not result in SGA. Tx of obesity. Other etiologies of SS where GH has not been shown to be associated with an increase in final height, including but not limited to achondrodoplasia and other skeletal dysplasias. GH tx used for reconstruction should not continue when BA =16 yr (M), or = 14 yr (F) is reached OR Epiphyseal fusion has occurred OR Mid-parenteral height is achieved. Child over 12: an X-ray report with evidence that epiphyses have closed or SMR of 3 or more.

PA Criteria	Criteria Details
Required Medical Information	Initial Requests, For idiopathic GHD, has signs/sym of GHD, GV 2 SD below age-appropriate mean or ht 2.25 SD below age-appropriate mean and A subnormal (SubNL) response (less than10ng/ml)to 2GH stim tests OR Neonates with hypoglycemia and clinical/hormone evidence of hypopit and low GH (less than 10ng/ml)OR 2other pit hormone deficiencies and low IGF-1 OR mbr has cranial irradiation with low IGF1 and normal thyroid tests.Child born SGA(birth wt or length 2 or more SD below the mean for gest age),Child fails to manifest catch up growth by age 2 yr(ht 2 or more SD below the mean for age,gender)AND Other causes for SS have been ruled out.Transitioning adolescent: completed linear growth(growth rate of less than 2cm/yr) AND either of the following: A)GH tx has been stopped at least a month and GHD reconfirmed by: 1)idiopathic isolated GHD(SubNL response to 2 GH stim tests OR SubNL response (GH conc of less than10 ng/mL)to 1 provocative test and low IGF-I/IGFBP-3) OR 2)multiple pit hormone deficiency,(SubNL response to 1 provocative GH test and/or low IGF-I/IGFBP-3)or 3) with cranial irradiation, low IGF with normal thyroid OR B) any of the following:known genetic mutation assoc with def GH production/secretion or Hypothalamic-pit tumor/structural defect or 3 other pit hormone deficiencies.Adult GHD confirmed/reconfirmed:SubNL response in adults to 2 GH stim tests (GH conc of less than or equal to 5ng/ml when using insulin induced hypoglycemia OR GH conc of less than or equal to 4.1ng/ml when using arginine)OR SubNL response to 1 stim test for adults with hypothalamic or pit dz and 1 pit hormone deficits OR 3 other pit hormone deficiencies.Initial requests for therapy in child: Reconstructive GH tx may be approved if either mean ht is at least 2.25 but less than 2.5SD below the mean for age, gender and GV is less than the 10th percentile over 1yr OR mean ht is at least 2.5SD below the mean for age, gender for conditions known responsive to GH.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	Continuation therapy in child (including reconstructive tx) when following are met: individ evaluated AND growth rate remains above 2.5cm/year (does not apply to children with prior documented hypopituitarism)(Grimberg2016). GH may be approved for Adolescents with childhood onset GHD who have completed linear growth. Treatment with GH in other populations approved when: Individual has AIDS wasting syndrome, defined as greater than 10% of baseline wt loss that cannot be explained by a concurrent illness other than HIV infection AND is being tx with antiviral therapy AND continues tx until above definition is no longer met OR individual dx with short bowel syndrome AND is receiving specialized nutritional support.
Indications	All Medically-accepted Indications.
Off Label Uses	

Humira

Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML, 40 MG/0.8ML (6 PACK), 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML, 80 MG/0.8ML
- HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 10 MG/0.2ML, 20 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.4ML, 40 MG/0.8ML

PA Criteria	Criteria Details
Exclusion Criteria	Using adalimumab in combination with other TNF agents, JAK inhiitors, or other biologic drugs (such as, Abatacept, anakinra or vedolizumab). Tuberculosis or other active serious infections or a history of recurrent infections. Individuals who have not had a tuberculin skin test or CDC-recommended equivalent to evaluate for latent tuberculosis prior to initiating adalimumab.
Required Medical Information	For Chronic moderate to severe plaque psoriasis with either of the following: Patient has greater than 5% of body surface area with plaque psoriasis OR Less than or equal to 5% of body surface area with plaque psoriasis involving sensitive areas or areas that significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia) AND agent is used to reduce signs/symptoms OR to induce/maintain clinical response.
Age Restrictions	Patient is 18 years of age or older for all indications except JIA, non-infectious Uveitis, Hidradenitis Suppurativa (HS) and Crohns disease. Patient must be at least 2 years old for JIA and non-infectious uveitis. Patient must be at least 6 years of age for Crohns disease. Patient must be at least 12 years old for HS.
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For moderate to severe RA, individual has had an inadequate response to, is intolerant of, or has a medical contraindication to ONE conventional therapy [nonbologic DMARDs (such as methotrexate, sulfasalazine, leflunomide, or hydroxylchloroquine)] (ACR 2015). For moderate to severe Psoriatic Arthritis, individual has had an inadequate response to, is intolerant of, has medical contraindication to ONE conventional therapy [non-biologic DMARDs (such as methotrexate, sulfasalazine or leflunomide)]. For moderate to severe Ankylosing Spondylitis (AS), individual has had an inadequate response to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as NSAIDs or nonbiologic DMARDs (such as sulfasalazine). For moderate to severe Crohn's disease, individual has had an inadequate response to, is intolerant of, or has a medical contraindication to ONE conventional therapy (e.g. 5-ASA products, sulfasalazine, systemic corticosteroids, or immunosuppressants). For chronic moderate to severe plaque psoriasis, individual has had an inadequate response to, is intolerant of, or has a medical contraindication to phototherapy or ONE other systemic therapy (e.g. methotrexate, acitretin, or cyclosporine). For moderate to severe Polyarticular Juvenile Idiopathic Arthritis (PJIA), individual has had an inadequate response to, is intolerant of, or has a medical contraindication to ONE conventional therapy [nonbologic DMARDs (such as methotrexate)] (ACR 2011). For moderate to severe Ulcerative Colitis (UC), individual has had an inadequate response to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as 5-ASA products, Sulfasalazine, systemic corticosteroids, or immunosuppressive drugs). For uveitis, individual has chronic, recurrent, treatment-refractory or vision-threatening disease and has had an inadequate response to, is intolerant of, or has a medical contraindication to conventional therapy (such as corticosteroids or immunosuppressive drugs [azathioprine, cyclosporine, or methotrexate]). For chronic, progressive, treatment-refractory Sarcoidosis (Sweiss 2014), individual has had an inadequate response
	to, is intolerant of or has a contraindication to systemic corticosteroids AND nonbiologic DMARDs (such as methotrexate or azathioprine). For moderate to severe Hidradenitis Suppurativa (Hurley stage II or Hurley stage III disease) AND has had an inadequate response to, is intolerant of, or has a medical contraindication to conventional therapy (such as oral antibiotics).
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	

Humulin U500

Products Affected

- HUMULIN R U-500 (CONCENTRATED) INJECTOR
- HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-

PA Criteria	Criteria Details
Exclusion Criteria	For use as a continuous subcutaneous infusion.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	Individual has a diagnosis of diabetes mellitus AND requires more than 200 units of insulin per day.
Indications	All Medically-accepted Indications.
Off Label Uses	

Ibrance

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Iclusig

Products Affected

- ICLUSIG ORAL TABLET 15 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Idhifa

Products Affected

- IDHIFA ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has confirmed (written or verbal attestation) isocitratedehydrogenase-2 (IDH2) mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Imbruvica

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Increlex

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	Individual has suspected or known malignancy. Individual has closed. Individual has of secondary IGF-1 deficiency (for example, due to GH deficiency, untreated malnutrition, untreated hypothyroidism).
Required Medical Information	For initial treatment of growth failure associated with severe primary IGF-1 deficiency as defined by: Height standard deviation score of less than or equal to -3.0 AND Basal IGF-1 standard deviation score of less than or equal to -3.0 AND normal or elevated growth hormone levels (greater than 10ng/mL on standard GH stimulation tests) are present OR GH gene deletion who have development of neutralizing antibodies to GH.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For Continuation of treatment with Increlex (mecasermin), Growth velocity is greater than or equal to 2cm (greater than equal to 2.0 cm) total growth in 1 year AND Final adult height has not been reached.
Indications	All Medically-accepted Indications.
Off Label Uses	

Inlyta

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Inrebic

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Interferons for MS

Products Affected

- AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT
- AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT
- BETASERON SUBCUTANEOUS KIT
- PLEGRIDY
- PLEGRIDY STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	Individuals with primary progressive MS. Individuals with secondary progressive MS without relapsing disease. Concurrent use with other MS disease modifying agents (such as Aubagio, Gilenya, tecfidera, tysabri, Lemtrada, Ocrevus, Copaxone/Glatopa, Extavoa. Rebif, Avonex, Plegridy or Betaseron).
Required Medical Information	Individual has experienced a first clinical episode and has MRI features consistent with multiple sclerosis OR Individual has a diagnosis of relapsing multiple sclerosis (RMS) OR Individual has secondary progressive MS (SPMS) with a history of superimposed relapses (AHFS).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Intuniv

Products Affected

- *guanfacine hcl er*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is using for Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder (ADHD/ADD).
Age Restrictions	Individual is 6 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ITRACONAZOLE

Products Affected

- *itraconazole oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For fingernail/toenail onychomycosis 12 weeks. For all other indications 1 year.
Other Criteria	For second-line non-onychomycosis indications include tinea infections (including, but limited to tinea versicolor, tinea cruris, tinea corporis, tinea pedis, tinea manuum, and tinea capitis) where the individual has received at least one prior topical therapy: clotrimazole, ketoconazole, econazole, or nystatin.
Indications	All Medically-accepted Indications.
Off Label Uses	

IVIG

Products Affected

- GAMUNEX-C INJECTION
  SOLUTION 1 GM/10ML
- OCTAGAM INTRAVENOUS
  SOLUTION 1 GM/20ML, 2 GM/20ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Hyperimmunoglobulinemia E synd when dx is evidenced by high level of serum IgE. Autoimmune mucocutaneous blistering dx when mbr had inadeq response/intolerance/contraindication to other tx such as corticosteroids,immunosuppressants. For autoimmune neutropenia, active INFECT is excluded as cause. For tx of 1 neurologic DZ: A) Lambert-Eaton myasthenic syndrome when having muscle weakness AND dx confirmed w/characteristic electrodiagnostic (ED) finding using nerve conduction tests, repetitive nerve stimulation (RNS), exercise testing or single fiber electromyography (SFE) or presence of antibodies (AB) directed against voltage-gated Ca channels B) Myasthenia Gravis (MG) and dx confirmed by presence of AB against the acetylcholine receptor or muscle specific tyrosine kinase or characteristic ED findings using RNS or SFE AND using for worsening sx or exacerbation or short-term therapy as immunosuppressive tx is taking effect or MAINT therapy of MG when mbr had inadeq response/intolerance/contraindication to other tx such as steroids, immunosuppressants C) Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), as INIT trial up to 12wks when muscle weakness or sensory dysfx is caused by neuropathy in more than 1 limb and nerve conduction studies or diagnostic criteria confirm evidence of demyelinating neuropathy and other polyneuropathies. For cont use of CIDP, clinically sig improvement in neurological sx on exam and cont need is shown by attempts on annual basis to titrate dose or interval of therapy result in sx worsening. As INIT exam(up to 12wks), clinical presentation w/electrodiagnostic test confirm MMN. For MMN cont use, mbr had improvement in strength and fx and need shown by attempts annually to titrate dose or interval therapy results in worse sx.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Tx of primary humoral immunprimaryodeficiency (PI) when hx of recurrent sinopulmonary infection (SI) req ABX tx AND lack of/inadeq response to immunization AND no evidence of renal (nephrotic synd) and GI as causes of hypogammaglobulinemia (HGG) AND INIT pre-tx total serum IgG below the lower limit of age adj lab ref range or more than 2SD below adj mean. hyperimmunoadj mean AND hx of recurrent SI requiring ABX therapy AND lack of/inadeq response to immunization OR Use for ONE: A) B-cell CLL w/ hx of recurrent bacterial or active INFECT not responding to antimicrobial therapy and HGG w/ total IgG less than 500mg/dL B)Multiple myeloma with hx of recurrent bacterial or clinically severe INFECT and HGG with total IgG less than 500mg/dL C) HIV infected children to prevent opportunistic bacterial infection w/HGG (IgG less than 400mg/dL) or recurrent INFECT D) PARVO B19 chronic INFECT and severe anemia assoc w/bone marrow suppression OR using in context of transplant for ONE: 1) hematopoietic stem cell transplant 2) Solid organ transplantation including prior desensitization for transplantation for suppression of panel reactive anti-HLA antibody (AB) in ppl with high panel reactive AB (PRA) levels to human leukocyte antigens OR Transplant recipients at risk of CMV 3) Transplant recipients experiencing AB-mediated rejection w/ donor-specific AB OR for tx of ONE autoimmune DZ: A) ITP w/either active bleed or platelet count less than 30,000 mcL B) Fetal alloimmune TCP w/AB to paternal platelet antigen in maternal serum and ONE: Previously affected PREG, family hx of maternofetal alloimmune TCP or fetal blood sample shows TCP C) Isoimmune hemolytic dx of newborn, tx of severe hyperbilirubinemia D) Dermatomyositis (DMM) or polymyositis when mbr had inadeq response/intolerance/contraindication to other tx,e.g., corticosteroids, immunosuppressive agents AND Dx confirmed having at least 4 sx: weak trunk/proximal extremities, high serum CK or aldolase levels, unexplainable muscle pain, electromyography findings, anti-Jo-1 AB, arthralgia/arthritis w/out joint destruction, sign of systemic inflamm, e.g.,fever/elevated C-

PA Criteria	Criteria Details
	reactive protein/high SED rate or inflamm myositis seen on muscle biopsy AND using for DMM and skin lesions present. For 1 MISC DX: post-exposure prophylaxis to stop measles, give in 6dys of exposure (not w/VACC having measles virus), eligible/exposed/non-immune mbr will get a VACC w/measles virus greater than/equal to 8 mth after Ig admin and used in mbrs at risk of severe dx/complications and no evidence of measles immunity in PREG or severely immunocompromised ppl OR for Kawasaki Dz tx initiated w/in 10dys of onset and tx for more than 5dys
Indications	All Medically-accepted Indications.
Off Label Uses	

Jadenu

Products Affected

- *deferasirox oral tablet 360 mg, 90 mg*
- JADENU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For dx non-transfusion-dependent thalassemia (NTDT) syndrome, 10 years of age or older. For dx of chronic iron overload, 2 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Jakafi

Products Affected

- JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Juxtapid

Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has a clinical diagnosis of homozygous familial hypercholesterolemia (HoFH), based on the presence of the following (Cuchel 2014, Singh 2015): (A) Genetic confirmation of two (2) mutant alleles at the LDL receptor, apoB, PCSK9 or ARH adaptor protein (LDLRAP1) gene locus OR (B) One of the following: 1. an untreated LDL-C concentration greater than 500 mg/dL (13 mmol/L) OR 2. Treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) AND one of the following: (i) cutaneous or tendonous xanthoma before age of 10 years OR (ii) untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than 190 mg/dL).
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has had an adequate trial and titration of Repatha and achieved suboptimal lipid lowering response.
Indications	All Medically-accepted Indications.
Off Label Uses	

Kadcyla

Products Affected

- KADCYLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Tumor(s) have been evaluated with an assay validated to predict HER2 positive (HER2+) protein overexpression. Individuals are considered HER2 positive (HER2+) as documented by one of the following, immunohistochemistry (IHC) 3+ or In Situ hybridization (ISH) positive by any of the following: Single probe average HER2 copy number greater than or equal to 6.0 signals/cell OR Dual-probe HER2/CEP 17 ratio greater than or equal to 2.0 OR Dual-probe HER2/CEP 17 ratio less than 2.0 with an average HER2 copy number greater than or equal to 6.0 signals/cell.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For metastatic breast cancer, individual has previously received trastuzumab and a taxane, separately or in combination. AND has either received prior therapy for metastatic disease OR developed disease recurrence during or within six (6) months of completing adjuvant therapy. Kadcyla is only used in a single line of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

Kalydeco

Products Affected

- KALYDECO ORAL PACKET
- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Using Kalydeco (ivacaftor) monotherapy, without concurrent use of lumacaftor or tezacaftor, for the F508del mutation in the CFTR gene.
Required Medical Information	Individual has a diagnosis of cystic fibrosis (CF). Individual has confirmed (verbal or written attestation) mutation positive result in the cystic fibrosis membrane conductance regulator (CFTR) gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Keveyis

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Exclusion Criteria	Individual has a diagnosis of hepatic insufficiency OR severe pulmonary obstruction OR a known hypersensitivity to sulfonamides OR individual is concurrently using high-dose aspirin.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial 3 months, renewal 1 year
Other Criteria	For initial therapy, individual experiences greater than or equal to one episode of muscle weakness per week. For continuation therapy individual has provided written or verbal attestation that the individual has achieved and sustained clinically significant improvement in the number of episodes of muscle weakness experienced per week.
Indications	All Medically-accepted Indications.
Off Label Uses	

Keytruda

Products Affected

- KEYTRUDA INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	Previous treatment with another programmed death receptor-1 (PD-1) blocking antibody agent. OR Presence of human immunodeficiency virus (HIV) infection, hepatitis B virus infection, or hepatitis C virus infection. Receiving therapy for an autoimmune disease or chronic condition requiring treatment with an immunosuppressant.
Required Medical Information	Current ECOG (Eastern Cooperative Oncology Group) performance status of 0-2.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For melanoma, used as single agent and tx is 1st line in untreated dz or 2nd line in dz progression while receiving or since completing most recent therapy. For adv melanoma w/lymph node, resected high risk stage III. For colorectal cancer, used as single agent, primary tx as single agent for unresectable metachronous metastases (defective mismatch repair/high microsatellite instability [dMMR/MSIH] only) and previous adjuvant FOLFOX or Cape OX w/in past 12mon or subsequent therapy as single agent if nivolumab or pembrolizumab not previously given following oxaliplatin-irinotecan and fluropyrimidine based therapy or oxaliplatin-irinotecan. For adv/metastatic NSCLC, used as 1st line, single agent, cytologically confirmed stage III or IV, tumor expresses PD_L1 gene on at least 1% or grtr of tumor cells, no sensitizing epidermal growth factor receptor (EGFR) mutations or anaplastic lymphoma kinase (ALK) translocations. For 1st line adv/metastatic nonsquamous NSCLC, used in combo w/pemetrexed and carboplatin, cytologically confirmed stage IIIb or IV, no sensitizing EFGR mutation or ALK translocations. For 1st line metastatic squamous NSCLC, used in combo with carboplatin and paclitaxel or nab-paclitaxel and cytologically confirmed stage IV and has not undergone prev systemic tx for dz. For CONT/MAINT of recurrent/metastatic nonsquamous NSCLC, used in combo w/pemetrexed if part of 1st line pembrolizumab/pemetrexed and platinum based regimen and achieved tumor response or stable dz after initial cytotoxic therapy. For CONT/MAINT therapy of recurrent/metastatic squamous NSCLC, used as single agent, given 1st line as part of pembrolizumab/carboplatin/paclitaxel regimen, achieved tumor response or stable dz after initial cytotoxic therapy. For metastatic NSCLC, Used 2nd line, single agent, tumors w/ PD-L1 gene expression level greater than/equal to 1% w/demonstrated dz progression or after platinum-containing chemo, ALK or EGFR genomic tumor aberrations present and dz progression on FDA approved therapy for aberrations prior to receiving pembrolizumab. For small cell lung cancer, used as single agent and demonstrated dz

PA Criteria	Criteria Details
	relapse w/in 6mon after complete or partial response or stable dz with initial tx or primary progressive dz and not received another PD-1 agent. For cHL, except for those with lymphocyte-predominant HL, or who have relapsed after 3 or more prior lines of therapy. For Merkel-cell carcinoma (MCC), used as single agent, Presence of metastatic or recurrent locoregional MCC determined to be not amendable to definitive surgery or radiation therapy. For unresectable or metastatic solid tumors (dMMR/MSIH only), used as single agent. For hepatocellular carcinoma, used as single agent, demonstrated dz progression or intolerance on or after tx w/an approved 1st line agent.
Indications	All Medically-accepted Indications.
Off Label Uses	

Kineret

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Individual is using Kineret in combination with other tumor necrosis factor (TNF) antagonists. Tuberculosis or other active serious infections or a history of recurrent infections. Individual has not had a tuberculin skin test (TST) or Centers for Disease Control (CDC) Prevention-recommended equivalent to evaluate for latent tuberculosis prior to initiating Kineret. In combination with Xeljanz (tofacitinib) or with NONTNF immunomodulatory drugs [such as but not limited to Actemra (tocilizumab) or Orencia (abacept)].
Required Medical Information	
Age Restrictions	For RA, individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For RA, Individual has had an inadequate response to is intolerant of or has a contraindication to at least ONE conventional therapy [disease modifying anti-rheumatic agent (DMARD)] AND Individual has had a trial and an inadequate response to or intolerance to Humira (adalimumab) OR Enbrel (etanercept) or the TNF agent (Humira(adalimumab)/Enbrel(etanercept)) tried and failed are not acceptable due to concomitant clinical conditions, such as but not limited to any of the following: (a) Known hypersensitivity or any active or inactive component which is not also associated with kineret or (b) Individual's age or (c) Pregnant or planning or becoming pregnant or (d) Serious infections or concurrent sepsis OR the individual has either concomitant clinical condition: 1) Demyelinating disease or 2) Heart failure with documented left ventricular dysfunction. Kineret may be allowed without trial of preferred TNF agents (Enbrel/Humira).

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

Kisqali

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Korlym

Products Affected

- KORLYM

PA Criteria	Criteria Details
Exclusion Criteria	History of unexplained vaginal bleeding. Current endometrial hyperplasia with atypia or endometrial carcinoma. Diagnosis of severe hepatic impairment (Child Pugh Class C). Concomitant use with any of the following: (1) Long term systemic corticosteroids for serious medical conditions or illnesses OR (2) Simvastatin or lovastatin OR (3) CYP3A substrates with narrow therapeutic ranges (such as but not limited to cyclosporine, fentanyl, sirolimus, tacrolimus) OR (4) Agents or co-morbid conditions which prolong the QT interval
Required Medical Information	
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Initial therapy: Individual is not a candidate for surgery that is expected to correct the cause of endogenous Cushing's Syndrome OR disease persists or recurs following surgery intended to correct the cause of endogenous Cushing's Syndrome. For continuation of therapy: Individual continues to meet the initial request approval criteria AND has experienced an improvement in or stabilization of glucose control as assessed by fasting serum glucose test, oral glucose tolerance test or hemoglobin A1c test.
Indications	All Medically-accepted Indications.
Off Label Uses	

Kuvan

Products Affected

- KUVAN

PA Criteria	Criteria Details
Exclusion Criteria	If blood phenylalanine levels do not decrease from baseline at a dose of 10mg/kg/day administered for up to one month. The dose may be increased up to 20mg/kg/day. Individuals are non-responders if phenylalanine levels do not decrease after 1 month and tx should be discontinued
Required Medical Information	For initial requests, Individual has Dx of Hyperphenylalaninemia (HPA) due to tetrahydrobiopterin-(BH4) responsive PKU. For continued use, individual is showing signs of continuing improvement as evidenced by blood phenylalanine levels.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial 8 weeks, 1 year for continuation
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Latuda

Products Affected

- LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For Schizophrenia, 13 years of age or older. For monotherapy treatment of depressive episodes associated with Bipolar I Disorder, 10 years of age or older. For all other indications, age 18 or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For schizophrenia, individual has had a trial of one of the following generic oral atypical antipsychotic agents: Aripiprazole, Risperidone, Olanzapine, Quetiapine fumarate, Paliperidone, or Ziprasidone.
Indications	All Medically-accepted Indications.
Off Label Uses	

Lazanda

Products Affected

- LAZANDA

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of acute or postoperative pain, migraine headache pain OR non-cancer related breakthrough pain
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of active cancer (such as, metastatic or locally invasive cancer for which the individual is currently seeking treatment) with breakthrough cancer pain (provide diagnosis) AND has tried and failed fentanyl citrate lozenge (generic Actiq) AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving around the clock medicine consisting of one of the following: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR At least 25mg of oral oxymorphone daily, OR An equianalgesic dose of another opioid for a week or longer. Individual will also continue around the clock opioids when taking Lazanda (fentanyl) for cancer related breakthrough pain.
Indications	All Medically-accepted Indications.
Off Label Uses	

Lenvima

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Letairis

Products Affected

- *ambrisentan*
- LETAIRIS

PA Criteria	Criteria Details
Exclusion Criteria	Individual has idiopathic pulmonary fibrosis (IPF). Individual has a diagnosis of moderate (Child-Pugh Class B) or severe (Child-Pugh Class C) hepatic impairment. Individual is initiating therapy and has a diagnosis of clinically significant anemia/severe anemia. Using in combination with other endothelin receptor antagonist (ERA) agents, such as but not limited to Opsumit (macitentan) or Tracleer (bosentan).
Required Medical Information	Individual has catheterization-proven diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1) AND individual has WHO Functional Class II-IV symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Lidocaine Topical

Products Affected

- *lidocaine hcl external solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	Individual is using for local analgesia OR Individual is using for relief of pain and itching due to minor cuts, minor scrapes, minor skin irritations, minor burns, and insect bites.
Indications	All Medically-accepted Indications.
Off Label Uses	

Lidoderm Patch

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Lonsurf

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Lorbrena

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Lotronex

Products Affected

- *alosetron hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is a Female with Severe diarrhea-predominant Irritable Bowel Syndrome (IBS) defined as including diarrhea and 1or more of the following: Frequent and severe abdominal pain/discomfort, Frequent bowel urgency or fecal incontinence, Disability or restriction of daily activities due to IBS. Member is female AND Member has chronic symptoms of IBS that have persisted for 6 months or longer AND does not have an anatomic or biochemical abnormality of the gastrointestinal tract.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has a documented trial of, an inadequate response or intolerance TWO (2) of the following medications: (a) Loperimide (b) antispasmodics (for example, dicyclomine), or (c) tricyclic antidepressants (AGA 2014).
Indications	All Medically-accepted Indications.
Off Label Uses	

Lupron Depot

Products Affected

- LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG
- LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 22.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Prostate cancer: Clinically localized dz with intermediate (T2b to T2c cancer, Gleason score of 7/Gleason grade group 2-3, or prostate specific antigen (PSA) value of 10-20 ng/mL) or higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR Other advanced, recurrent, or metastatic disease. For Gynecology Uses: Initial treatment/retreatment of endometriosis (not to continue beyond 6 months) OR Dysfunctional uterine bleeding OR Preoperative tx as adjunct to surgical tx of uterine fibroids (leiomyoma uteri). May be used to reduce size of fibroids to allow for a vaginal procedure, prior to surgical tx (myomectomy or hysterectomy) in patients with documented anemia (Letheby et al. 2001). To induce amenorrhea in women (such as but not limited to menstruating women diagnosed with severe thrombocytopenia or aplastic anemia). For Endocrine Uses: Precocious puberty, defined as beginning of secondary sexual characteristics before age 8 in girls and before age 9 in boys. Ovarian Cancer (including fallopian tube cancer and primary peritoneal cancer): Hormonal therapy for clinical relapse in individuals with stage II-IV granulosa cell tumors or Hormonal therapy for treatment of epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer as a single agent for persistent dz or recurrence.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year, except for Endometriosis:6months, Uterine Fibroids:3months

PA Criteria	Criteria Details
Other Criteria	For Gender Dysphoria in Adolescents (Hembree 2009)m 2017): Fulfills the DSM V criteria for gender dysphoria (American Psychiatric Assoc 2013) AND has experienced puberty to at least Tanner stage 2 (Hembree 2009, 2017) AND has (early) pubertal changes that have resulted in an increase of their gender dysphoria (Hembree 2009, 2017) AND does not suffer from a psychiatric comorbidity that interferes with the diagnostic work-up or treatment (Hembree 2009, 2017) AND has psychological and social support during treatment (Hembree 2009, 2017) AND demonstrates knowledge and understanding of the expected outcomes of GnRH analog treatment(Hembree 2009, 2017).
Indications	All Medically-accepted Indications.
Off Label Uses	

Lupron Kit IR

Products Affected

- *leuprolide acetate injection*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7/Gleason grade group 2-3, or prostate specific antigen (PSA) value of 10-20 ng/mL) or higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR Other advanced, recurrent, or metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Lynparza

Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Test results from an FDA-approved test confirms (written or verbal) the BRCA mutation for individuals with ovarian cancer or individuals with metastatic human epidermal growth factor receptor 2 (HER2) negative breast cancer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Mavyret

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes a genotype and a positive HCV RNA result (AASLD/IDSA 2017, CDC 2013) AND Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy AND Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	

Megace Suspension HRM

Products Affected

- *megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is using for the treatment of anorexia, cachexia, or unexplained weight loss in individuals with HIV/AIDS. Prescriber must acknowledge this is a high risk medication (HRM) [as identified by American Geriatric Society] for individuals greater than 65 and medication benefits outweigh potential risk for this individual
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Megace Tabs HRM

Products Affected

- *megestrol acetate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) [as identified by American Geriatric Society] for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has advanced, inoperable, recurrent breast cancer and using for palliative management. Individual has endometrial/uterine cancer and is suing for palliative management.
Indications	All Medically-accepted Indications.
Off Label Uses	

Mekinist

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BRAF V600E or V600K mutation results must be confirmed (written or verbal attestation).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Mektovi

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BRAF V600E or V600K mutation results must be confirmed (written or verbal attestation is acceptable).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Mepron

Products Affected

- *atovaquone oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Intolerance to trimethoprim-sulfamethoxazole (TMP-SMX)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Methylphenidate

Products Affected

- *methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg*
- *methylphenidate hcl oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is using for Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder (ADHD/ADD) or Narcolepsy.
Age Restrictions	6 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Modafinil

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Narcolepsy type 1: confirmed by the presence of daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months and at least one of the following: 1. Clear cataplexy (defined as more than one episode of generally brief) usually bilaterally symmetrical, sudden loss of muscle tone with retained consciousness) AND 2.Multiple Sleep Latency Test (MSLT) showing one of the following: a. Mean sleep latency of less than 8 minutes with evidence of two sleep-onset rapid eye movement periods (SOREMPs) (ICSD-3, 2014)OR b. At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) OR 3.Cerebrospinal fluid hypocretin-1 deficiency (less than 110 pg/mL or less than one-third of the normative values with the same standardized assay). For Narcolepsy type 2: confirmed by 1.Multiple sleep latency test (MSLT) with one of the following: a.Mean sleep latency of less than 8 minutes with and evidence of two sleep-onset rapid eye movement periods (SOREMPs) ICSD-3, 2014) OR b. At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) AND 2.The absence of cataplexy AND 3.Exclusion of alternative causes of excessive daytime sleepiness by history, physical exam and Polysomnography.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For obstructive sleep apnea/hypopnea syndrome objectively confirmed by polysomnography (PSG) or home testing with portable monitor showing one of the following (AASM 2009): (1).Greater than 15 obstructive events (defined as apneas, hypopneas plus respiratory event related arousal) per hour of sleep OR (2)Greater than 5 obstructive events per hour of sleep and individual reports any of the following: a.Unintentional sleep episodes during wakefulness or b. Daytime sleepiness or c. Unrefreshing sleep or d. Fatigue or e. Insomnia or f.Waking up breath holding, gasping or choking or g.Bed partner describing loud snoring, breathing interruptions or both or h. Presence of comorbid conditions including hypertension, mood disorder, cognitive dysfunction, coronary artery disease, stroke, congestive heart failure, atrial fibrillation or type 2 diabetes mellitus. And has an Epworth Sleepiness Scale score greater than or equal to 10. For Shift-Work Sleep Disorder (SWSD) confirmed by all of the following: (1)No other medical disorder or mental disorder accounts for the symptoms AND (2)Symptoms do not meet criteria for any other sleep disorder (i.e. jet lag) AND (3)Symptoms have occurred for at least 3 months, AND (4)Individual has one of the following: a.Individual has excessive sleepiness or insomnia associated with a work period that occurs during the usual sleep phase OR b.Polysomnography demonstrates loss of a normal sleep-wake pattern (such as, disturbed chronobiological rhythmicity).
Indications	All Medically-accepted Indications.
Off Label Uses	

Myalept

Products Affected

- MYALEPT

PA Criteria	Criteria Details
Exclusion Criteria	Individual is using for the treatment of complications of partial lipodystrophy. Individual is using for the treatment of liver disease, including nonalcoholic steatohepatitis (NASH). Individual is using for the treatment of HIV-related lipodystrophy. Individual is using for treatment in patients with general obesity or metabolic disease, including diabetes mellitus and hypertriglyceridemia, without concurrent evidence of congenital or acquired generalized lipodystrophy
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Namenda Line

Products Affected

- *memantine hcl er*
- *memantine hcl oral solution*
- *memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individuals that are 50 years of age or older are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 49 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of moderate to severe dementia of the Alzheimer's type.
Indications	All Medically-accepted Indications.
Off Label Uses	

Natpara

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	Serum corrected total calcium levels maintained within therapeutic range on calcium supplements and active vitamin D forms alone OR serum corrected total calcium level of less than or equal to 7.5 mg/dL at initiation of therapy. Individual is using to treat hypoparathyroidism caused by a gene mutation in the calcium-sensing receptor OR using to treat acute (duration of less than 6 months, Bilezikian et al. 2011) postoperative hypoparathyroidism OR Individual is at increased risk for osteosarcoma (such as but not limited to, concomitant Paget's disease of bone, open epiphyses, prior history of skeletal external beam or implant radiation therapy).
Required Medical Information	
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Diagnosis of chronic (duration of greater than or equal to 18 months, mannstadt et, al 2013) hypoparathyroidism.
Indications	All Medically-accepted Indications.
Off Label Uses	

Nerlynx

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Nexavar

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed (verbal or written attestation) results of FLT3-ITD mutation with acute myeloid leukemia, relapsed/refractory disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Ninlaro

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	For multiple myeloma, individual received at least two prior therapies, including immunomodulatory agent and a proteasome inhibitor AND demonstrated disease progression on or within 60 days of completion therapy AND Ninlaro is given as part of a treatment regimen containing dexamethasone and pomalidomide.
Indications	All Medically-accepted Indications.
Off Label Uses	

Nityr

Products Affected

- NITYR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual's plasma tyrosine level is maintained below 500 micromol/L to reduce risk of ocular symptoms, developmental delay, or hyperkeratotic plaques.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Northera

Products Affected

- NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has had a trial (resulting in inadequate response, therapeutic failure or intolerance) of at least one prior pharmacologic therapy (which may include midodrine or fludrocortisone) for treatment of symptoms of NOH.
Indications	All Medically-accepted Indications.
Off Label Uses	

Noxafil

Products Affected

- NOXAFIL ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

NP CSF SA Agents

Products Affected

- NIVESTYM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Febrile neutropenic individuals who are at risk for infection-associated complications or have any of the following: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10to the power of 9/L) neutropenia, Age greater than 65 years, Pneumonia or other clinically documented infection, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, prior episode of FN, or Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than 20% based on chemotherapy in patients who have other patient specific risk factors for FN including any of the following: Individual age greater than 65 years, Poor performance status (ECOG status 3-4), prior chemotherapy or radiation therapy, Bone marrow involvement by tumor producing cytopenias, persistent neutropenia (ANC less than 1500mm3), poor renal function (GFR less than 60mL/min) , liver dysfunction (liver function tests at least 2x upper limit of normal) or recent surgery and/or presence of open wounds.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.

PA Criteria	Criteria Details
Other Criteria	Individual has had a trial and inadequate response to intolerance to Zarxio (Filgrastim-sndz). Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. Using for adjunctive tx for FN and has been prophylactic therapy with GCSF agent or has not received prophylactic therapy with a GCSF and who are at high risk for infection-associated complications. Use in acute lymphocytic leukemia (ALL) after completion of the first few days of initial induction chemotherapy or first post-remission course of chemotherapy. Use in individuals with acute myeloid leukemia (AML) shortly after the completion of induction or repeat induction chemotherapy, or after the completion of consolidation chemotherapy for AML. For tx of moderate to severe aplastic anemia. Tx of severe neutropenia in individuals with hairy cell leukemia. For myelodysplastic syndromes (MDS) with severe neutropenia (absolute neutrophil count (ANC) less than or equal to 500 mm3 or experiencing recurrent infection. For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for adjuvant treatment of breast cancer. For chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic individuals with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. For tx of (non-chemotherapy) drug-induced neutropenia. For tx of low neutrophil counts in individuals with glycogen storage disease type 1b. For tx of neutropenia associated with human immunodeficiency virus (HIV) infection and antiretroviral therapy. In individuals receiving radiation therapy in the absence of chemotherapy if prolonged delays secondary to neutropenia are expected. After accidental or intentional total body radiation of myleosuppressive doses (greater than 2 Grays [Gy] (such as Hematopoietic Syndrome of Acute Radiation Syndrome). After hematopoietic progenitor stem cell transplant (HPCT/HSCT) to
	promote myeloid reconstitution or when engraftment is delayed or has failed. To mobilize progenitor cells into peripheral blood for collection by leukapheresis, as an adjunct to peripheral blood/hematopoietic stem cell transplantation (PBSCT/PHSCT). Use as an alternate or adjunct to donor leukocyte infusions (DLI) in individuals with leukemic relapse after an allogeneic hematopoietic stem cell transplant.

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

NP Human Growth Hormone

Products Affected

- ZORBTIVE

PA Criteria	Criteria Details
Exclusion Criteria	Use of GH tx when applicable criteria have not been met may not be approved for, but not limited to, the following: Renal transplant, Anabolic tx, except for AIDS, provided to counteract acute or chronic catabolic illness (e.g. surgery, trauma, cancer,chronic hemodialysis) producing catabolic (protein wasting) changes in both adult and ped. Anabolic tx to enhance body mass or strength for professional, recreational or social reasons, Constitutional delay of growth and development. Cystic fibrosis, GH Tx in combo with GnRH agonist (Lupron-leuprolide) as a Tx of precocious puberty. Hypophosphatemic rickets, osteogenesis imperfecta, osteoporosis, Short Stature associated with GH insensitivity (Laron Syndrome). Therapy in older adults with normally occurring decrease in GH, who are not congenitally GH deficient and who have no evidence of organic pituitary dz (this is referred to as age-related GH deficiency). Tx of CHF, burn patients, fibromyalgia, glucocorticoid-induced growth failure. Tx of HIV lipodystrophy (fat redistribution syndrome), also referred to as altered body habitus (e.g. buffalo hump), associated with antiviral therapy in HIV-infected patients. Tx of intrauterine growth restriction (IUGR)or Russell-Silver Syndrome that does not result in SGA. Tx of obesity. Other etiologies of SS where GH has not been shown to be associated with an increase in final height, including but not limited to achondrodoplasia and other skeletal dysplasias. CONT therapy: evaluated annually AND growth rate above 2.5cm/yr (not for child w/prior documented hypopituitarism)(Grimberg 2016) AND Child over 12: an X-ray report with evidence that epiphyses have closed or SMR of 3 or more. GH tx for reconstruction is terminated when BA =16 yr (M), or = 14 yr (F) is reached OR Epiphyseal fusion has occurred OR Mid-parenteral height is achieved.

PA Criteria	Criteria Details
Required Medical Information	For initial idiopathic GHD requests, has signs/sym sx of GHD, GV 2 SD below age-appropriate mean or ht 2.25 SD below age-appropriate mean and A subnormal (SubNL) response (less than10ng/ml)to 2GH stim tests OR Neonates with hypoglycemia and clinical/hormone evidence of hypopit and low GH (less than 10ng/ml)OR 2other pit hormone deficiencies and low IGF-1 OR mbr has cranial irradiation with low IGF1 and normal thyroid tests.Child born SGA(birth wt or length 2 or more SD below the mean for gest age),Child fails to manifest catch up growth by age 2 yr(ht 2 or more SD below the mean for age,gender)AND Other causes for SS have been ruled out.Transitioning adolescent: individual completed linear growth (less than 2cm/yr) AND either GH tx has been stopped for at least a month, and GHD has been reconfirmed:idiopathic isolated GHD(SubNL response to 2 GH stim tests, OR SubNL response (GH conc of less than10 ng/mL)to 1 provocative test and low IGF-I/IGFBP-3)OR multiple pit hormone deficiency,(SubNL response to 1 provocative GH test and/or low IGF-I/IGFBP-3)or for mbr with cranial irradiation, low IGF with normal thyroid or any of the following, known genetic mutation associated with def GH production or secretion or Hypothalamic-pit tumor or structural defect or 3 other pit hormone deficiencies.Adult GHD must be confirmed/reconfirmed:SubNL response in adults to 2 GH stim tests (GH conc of less than or equal to 5ng/ml when using insulin induced hypoglycemia OR GH conc of less than or equal to 4.1ng/ml when using arginine)OR SubNL response to 1 stim test for adults with hypothalamic or pit dz and 1 pit hormone deficits OR 3 other pit hormone deficiencies.Initial request for Reconstructive GH tx in child w/ mean ht is at least 2.25 but less than 2.5SD below the mean for age, gender and GV is less than 10th percentile over 1yr or mean ht at least 2.5SD below the mean for age, gender for conditions known responsive to GH.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For Non Preferred Growth hormone agents, individual has had trial of TWO preferred GH agents (Norditropin AND Omnitrope) or preferred GH agent is not FDA-approved and does not have an accepted off-label use per CMS recognized compendia for the prescribed indication and the requested non-preferred agent is. GH may be approved for Adolescents with childhood onset GHD who have completed linear growth. GH tx in other populations approved when: individual has AIDS wasting (defined as greater than 10% of baseline wt loss that is not explained by concurrent illness other than HIV) AND is being treated with antiviral therapy AND will continue tx until definition not met OR individual dx with short bowel syndrome AND is receiving specialized nutritional support.
Indications	All Medically-accepted Indications.
Off Label Uses	

NP LA Opioid

Products Affected

- *methadone hcl oral tablet*
- *morphine sulfate er beads*
- *morphine sulfate er oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg*
- *tramadol hcl er (biphasic)*
- *tramadol hcl er oral tablet extended release 24 hour*

PA Criteria	Criteria Details
Exclusion Criteria	Individual is requesting or using as an as-needed analgesic OR Individual has one of the following conditions: (a) Significant respiratory depression OR (b) Acute or severe bronchial asthma or hypercarbia OR (c) Known or suspected paralytic ileus.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial 3 months. Maintenance 6 months. Cancer Pain/Terminal Dx or Palliative Care 1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use, Individual has one of the following: (a) Diagnosis of cancer related pain and/or is actively undergoing cancer therapy (provide cancer diagnosis) OR (b) Diagnosis of terminal illness and is receiving palliative/end-of-life care (provide terminal diagnosis) OR Individual has pain severe enough to require daily, around-the-clock, long term opioid treatment (provide diagnosis) AND Individual has one of the following: (a) An inadequate response to ONE alternative treatment options, such as but not limited to non-opioid analgesics and immediate-release opioids OR (b) Alternative treatment options would otherwise be inadequate to provide sufficient management of pain OR (c) Individual has contraindications to non-opioid analgesics (such as NSAID use in individuals with active ulcer condition/gastrointestinal bleeding, renal failure) AND for initial therapy, individual is not opioid naïve as noted by the following: (a) Individual is currently using a short-acting opioid analgesic, including use of opioid analgesia as an inpatient for post-surgical pain OR (b) Individual is transitioning from one long-acting opioid analgesic to another long-acting opioid analgesic. For continued use, Attestation (verbal or written) that long-acting opioid therapy has provided meaningful improvement in pain and/or function compared to baseline AND Prescriber has consulted individual regarding risks of opioid therapy AND clear treatment goals have been defined and outline as part of overall plan AND has one of the following: Diagnosis of cancer related pain and/or is actively undergoing cancer therapy (provide cancer diagnosis) OR diagnosis of terminal illness and is receiving palliative/end-of-life care (provide terminal diagnosis) OR has pain severe enough to require daily, around-the-clock, long term opioid treatment (provide diagnosis).
Indications	All Medically-accepted Indications.
Off Label Uses	

NP LA Opioid Abuse Deterrent

Products Affected

- *buprenorphine transdermal patch weekly 10 mcg/hr, 15 mcg/hr, 20 mcg/hr, 5 mcg/hr, 7.5 mcg/hr*

PA Criteria	Criteria Details
Exclusion Criteria	Individual is requesting or using as an as-needed analgesic OR Individual has one of the following conditions: (a) Significant respiratory depression OR (b) Acute or severe bronchial asthma or hypercarbia OR (c) Known or suspected paralytic ileus.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial 3 months. Maintenance 6 months. Cancer Pain/Terminal Dx or Palliative Care 1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use, Individual has one of the following: (a) Diagnosis of cancer related pain and/or is actively undergoing cancer therapy (provide cancer diagnosis) OR (b) Diagnosis of terminal illness and is receiving palliative/end-of-life care (provide terminal diagnosis) OR Individual has pain severe enough to require daily, around-the-clock, long term opioid treatment (provide diagnosis) AND Individual has one of the following: (a) An inadequate response to ONE alternative treatment options, such as but not limited to non-opioid analgesics and immediate-release opioids OR (b) Alternative treatment options would otherwise be inadequate to provide sufficient management of pain OR (c) Individual has contraindications to non-opioid analgesics (such as NSAID use in individuals with active ulcer condition/gastrointestinal bleeding, renal failure) AND for initial therapy, individual is not opioid naïve as noted by the following: (a) Individual is currently using a short-acting opioid analgesic, including use of opioid analgesia as an inpatient for post-surgical pain OR (b) Individual is transitioning from one long-acting opioid analgesic to another long-acting opioid analgesic. AND If an abuse deterrent formulation is needed [such as but not limited to Embeda ER, Hysingla ER, Targiniq ER, Troxyca ER, Xtampza ER and Zohydro ER], and individual has a history of substance abuse disorder OR individual's family member or household resident has active substance abuse disorder or a history of substance abuse disorder OR If is there is concern for abuse or dependence with pure opioid agents. For continued use, Attestation (verbal or written) that long-acting opioid therapy has provided meaningful improvement in pain and/or function compared to baseline AND Prescriber has consulted individual regarding risks of opioid therapy AND clear treatment goals have been defined and outline as part of overall plan AND has one of the following: Diagnosis of cancer related pain and/or is actively undergoing cancer therapy (provide cancer diagnosis) OR diagnosis of terminal illness and is receiving palliative/end-of-life care (provide terminal diagnosis) OR has pain severe enough to require
	daily, around-the-clock, long term opioid treatment (provide diagnosis).
Indications	All Medically-accepted Indications.
Off Label Uses	

NP SGLT2

Products Affected

- FARXIGA 300 MG
- INVOKAMET
- INVOKAMET XR
- INVOKANA ORAL TABLET 100 MG,

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	Individual has had a trial and inadequate response or intolerance to metformin OR has a contraindication to metformin therapy [such as but not limited to, renal insufficiency (eGFR is less than 45 mL/minute/1.73m2)]. AND has had a trial and inadequate response or intolerance to Jardiance (empagliflozin), Synjardy (empagliflozin/metformin), or Synjardy XR (empagliflozin/metformin extended-release).
Indications	All Medically-accepted Indications.
Off Label Uses	

NP Topical Androgens

Products Affected

- *testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 25 mg/2.5gm (1%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older. For transgender use, individual is 16 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has had a trial of androgel 1.62% AND Individual has a dx of one: (1) primary hypogonadism (congenital or acquired) (for example, bilateral torsion, cryptorchidism, chemotherapy, Klinefleter Syndrome, orchitis, orchiectomy, toxic damage from alcohol or heavy metals, vanishing testis syndrome, idiopathic primary hypogonadism, age-related hypogonadism [also referred to as late-onset hypogonadism]) OR (2) Hypogonadotropic hypogonadism (also called secondary hypogonadism) (congenital or acquired) [for example, idiopathic gonadotropin or luteinizing hormone-relapsing hormone (LHRH) deficiency, pituitary-hypothalamic injury] OR (3) Individual is transgender AND is using for a diagnosis of gender Dysphoria or gender Identity Disorder AND Goal of treatment is female-to-male gender reassignment.
Indications	All Medically-accepted Indications.
Off Label Uses	

NP TZD

Products Affected

- AVANDIA ORAL TABLET 2 MG, 4 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has had a trial and inadequate response or intolerance to metformin OR Individual has a contraindication to metformin therapy [such as but not limited to, renal insufficiency (eGFR is less than 45mL/minute/1.73m2)] AND Individual has had a trial with ONE of the following: dipeptidyl peptidase-4 (DPP-4), glucagon-like peptide-1 (GLP-1), or a sodium-glucose co-transporter-2 (SGLT2) inhibitor.
Indications	All Medically-accepted Indications.
Off Label Uses	

Nubeqa

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Nucala

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For severe eosinophilic asthma: In the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease and known or suspected parasitic infections, the individual has a blood eosinophil count that is either greater than or equal to 150 cells/microliter at ignition of therapy OR greater than or equal 300 cells/microliter in the prior 12 months. Evidence of asthma is demonstrated by the following (NAEPP 2008): The individual has a pretreatment forced expiratory volume in one second (FEV1) less than 80% predicted AND FEV1 reversibility of at least 12% and 200mL after albuterol (salbutamol) administration.
Age Restrictions	For eosinophilic asthma: 6 years old or older. For eosinophilic granulomatosis with polyangitis (EGPA): 18 years old or older.
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For severe eosinophilic asthma, individual has had a 3 month trial/inadequate response to combination controller therapy (high dose inhaled corticosteroids plus LA beta2-agonist, leukotriene modifiers, theophylline or oral corticosteroids) (ERS/ATS 2013) AND has experienced 2 or more asthma exacerbations in the prior 12 months requiring use of a systemic corticosteroid or temporary increase in the individual's usual maintenance of oral corticosteroids (ERS/ATS 2013). For Continuation Therapy after 12 months in individuals with severe eosinophilic asthma: Treatment has resulted in clinical improvement as confirmed by either i) Decreased utilization of rescue medications OR ii) A decreased frequency of exacerbation (defined as worsening of asthma that requires increase in inhaled corticosteroid dose or treatment with systemic corticosteroid) OR iii) An increase in percent predicted FEV1 from pretreatment baseline OR iv) A reduction in reported asthma-related symptoms, such as, to wheezing, shortness of breath, coughing, fatigue, sleep disturbance or asthmatic symptoms upon awakening. For individuals with relapsing or refractory eosinophilic granulomatosis with polyangiitis for 6 months or greater and 1) a history or presence of asthma and 2) blood eosinophil level of greater than or equal to 10% of leucocytes or an absolute eosinophil count of greater than 1000 cells per cubic millimeter (in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease and known or suspected parasitic infection) and 2) the presence of 2 or more features of eosinophilic granulomatosis with polyangiitis (such as, biopsy showing histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration or eosinophil-rich granulomatosis inflammation, neuropathy, mono or poly(motor deficit or nerve conduction abnormality), pulmonary infiltrates, non-fixed sino-nasal abnormality, cardiomyopathy, glomerulonephritis, alveolar hemorrhage, palpable purpura or antineutrophil cytoplasmic antibody positive status. For Continuation Therapy after 12 months in individuals with eosinophilic granulomatosis with polyangiitis when treatment has resulted in clinical improvement as confirmed by the
	achievement of remission at some point during tx, defines as the following: Birmingham Vasculitis Activity Score, version 3, of zero on scale from 0 to 63 and receipt of prednisolone or prednisone at dose of 4mg or less per day.
Indications	All Medically-accepted Indications.
Off Label Uses	

Nuedexta

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with any of the following: (i.) Agents containing quinidine, quinine, or mefloquine OR (ii.) Agents that both prolong the QT interval and are metabolized by CYP2D6 (for example, thioridazine, pimozide) OR Concomitant monoamine oxidase inhibitor (MAOI) use or use in the preceding 14 days OR Individual has any of the following cardiovascular conditions: (i.)Prolonged QT interval, congenital long QT syndrome, or history suggestive of torsades de pointes OR (ii.) Heart failure OR (iii.) Complete atrioventricular (AV) block without an implanted pacemaker or at high-risk of a complete AV block.
Required Medical Information	
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	Individual has a diagnosis of pseudobulbar affect (PBA) AND has a concomitant diagnosis with an unrelated neurologic disease or injury [amyotrophic lateral sclerosis (AAN 2014, Pioro et al. 2010), multiple sclerosis (AAN 2016, Pioro et al, 2010), stroke (2016 AHA/ASA)].
Indications	All Medically-accepted Indications.
Off Label Uses	

Nuplazid

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial:3 months, Maintenance: 1 Year
Other Criteria	Initial therapy: Individual has a diagnosis of Parkinson's disease AND Symptoms of psychosis developed after the PD diagnosis AND Symptoms of psychosis include at least one of the following: (1) Visual hallucinations, (2) Auditory hallucination OR (3) Delusions AND Symptoms have been present for at least one month AND Individual has experienced symptoms at least once weekly. Psychiatric symptoms cannot be attributed to disorders such as schizophrenia, schizoaffective disorder, delusional disorder, or mood disorder with psychotic features, or a general medical condition including delirium. For continued therapy, the individual has had a reduction in symptoms of psychosis compared to baseline.
Indications	All Medically-accepted Indications.
Off Label Uses	

Nuvigil

Products Affected

- *armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Narcolepsy type 1: confirmed by the presence of daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months and at least one of the following: 1. Clear cataplexy (defined as more than one episode of generally brief) usually bilaterally symmetrical, sudden loss of muscle tone with retained consciousness) AND 2.Multiple Sleep Latency Test (MSLT) showing one of the following: a. Mean sleep latency of less than 8 minutes with evidence of two sleep-onset rapid eye movement periods (SOREMPs) (ICSD-3, 2014)OR b. At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) OR 3.Cerebrospinal fluid hypocretin-1 deficiency (less than 110 pg/mL or less than one-third of the normative values with the same standardized assay). For Narcolepsy type 2: confirmed by 1.Multiple sleep latency test (MSLT) with one of the following: a.Mean sleep latency of less than 8 minutes with and evidence of two sleep-onset rapid eye movement periods (SOREMPs) ICSD-3, 2014) OR b. At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) AND 2.The absence of cataplexy AND 3.Exclusion of alternative causes of excessive daytime sleepiness by history, physical exam and Polysomnography.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For obstructive sleep apnea/hypopnea syndrome objectively confirmed by polysomnography (PSG) or home testing with portable monitor showing one of the following (AASM 2009): (1).Greater than 15 obstructive events (defined as apneas, hypopneas plus respiratory event related arousal) per hour of sleep OR (2)Greater than 5 obstructive events per hour of sleep and individual reports any of the following: a.Unintentional sleep episodes during wakefulness or b. Daytime sleepiness or c. Unrefreshing sleep or d. Fatigue or e. Insomnia or f.Waking up breath holding, gasping or choking or g.Bed partner describing loud snoring, breathing interruptions or both or h. Presence of comorbid conditions including hypertension, mood disorder, cognitive dysfunction, coronary artery disease, stroke, congestive heart failure, atrial fibrillation or type 2 diabetes mellitus. And has an Epworth Sleepiness Scale score greater than or equal to 10. For Shift-Work Sleep Disorder (SWSD) confirmed by all of the following: (1) No other medical disorder or mental disorder accounts for the symptoms AND (2)Symptoms do not meet criteria for any other sleep disorder (i.e. jet lag) AND (3) Symptoms have occurred for at least 3 months, AND (4) Individual has one of the following: a.Individual has excessive sleepiness or insomnia associated with a work period that occurs during the usual sleep phase OR b.Polysomnography demonstrates loss of a normal sleep-wake pattern (such as, disturbed chronobiological rhythmicity).
Indications	All Medically-accepted Indications.
Off Label Uses	

Ocaliva

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	Individual has a diagnosis of nonalcoholic steatohepatitis (NASH), nonalcoholic fatty liver disease (NAFLD), primary sclerosing cholangitis (PSC), or biliary atresia. Individual has complete biliary obstruction.
Required Medical Information	Individual has a diagnosis of primary biliary cholangitis (PBC) as confirmed by TWO of the following (Lindor, 2009): (a) Elevated alkaline phosphatase. (b) Positive antimitochondrial antibodies (AMA) titer. (c) Liver biopsy with findings consistent with PBC.
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For Initial request, Individual has had a one year trial of ursodiol (Urso 250, Urso Forte) with an inadequate response as demonstrated by one of the following (FDA Ad Com, Lindor, 2009): (a) Alkaline phosphatase greater than or equal to 1.67 times the upper limit of normal OR (b) Total bilirubin greater than the upper limit of normal but less than two times the upper limit of normal) AND Individual will be utilizing Ocaliva (obeticholic acid) in combination with ursodiol (Urso 250, Urso Forte) OR has an intolerance to ursodiol (Urso 250, Urso Forte). For continuing treatment with Ocaliva (obeticholic acid), individual has previously met the initiation criteria above and: (a) Individual has achieved an adequate response of alkaline phosphatase or total bilirubin AND (b) Documentation has been provided.
Indications	All Medically-accepted Indications.
Off Label Uses	

Octreotide Line

Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.

PA Criteria	Criteria Details
Other Criteria	Individual has (A) diagnosis of carcinoid tumors for any of the following: Metastatic carcinoid tumors OR Carcinoid syndrome to suppress or inhibit severe diarrhea and flushing episodes associated with the disease OR Prophylactic administration prior to biopsy in an individual with a suspected functioning carcinoid tumor OR Prophylactic administration prior to induction of anesthesia in an individual with a functional carcinoid tumor OR Prophylactic administration to a surgical procedure in an individual with a functional carcinoid tumor. OR (B) Diagnosis of Bleeding gastroesophageal varices when GE varices are associated with liver disease AND octreotide acetate is used in combination with endoscopic therapy or alone if endoscopic therapy is not available. OR (C) Chemotherapy or radiation-induced diarrhea that is unresponsive to conventional antidiarrheal medications (for example, diphenoxylate and atropine or loperamide) OR (D) Malignant bowel obstruction to manage GI symptoms (such as nausea, vomiting or pain). OR (E) central nervous system meningiomas that are surgically inaccessible, recurrent, or progressive and is not a candidate for further radiation therapy OR (F) thymic carcinoma or thymoma with or without prednisone OR (G) Using for rapid relief of symptoms or for breakthrough symptoms in individuals taking long-acting octreotide acetate when any of the criteria are met for the above uses OR (H) Neuroendocrine Tumors: (i) Management of unresectable locoregional disease or distant metastasis or (ii) As treatment of the profuse watery diarrhea associated with VIPomas or (iii) Treatment of underlying hypergastrinemic Zollinger-Ellison syndrome or (iv) Prophylactic treatment prior to surgery for gastrinoma.
Indications	All Medically-accepted Indications.
Off Label Uses	

Odomzo

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Ofev

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	Using in combination with Esbriet (pirfenidone). Individuals with severe hepatic impairment (child pugh class C) or end-stage liver disease.
Required Medical Information	Diagnosis of idiopathic pulmonary fibrosis (IPF) is confirmed by: Exclusion of other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity AND High resolution computed tomography (HRCT) with or without surgical lung biopsy. Individual has documented pulmonary function tests within prior 60 days with a Forced Vital Capacity (% FVC) greater than or equal to 50%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Onfi

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet 10 mg, 20 mg*
- SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis (all ages) and if over 65 years of age or older, Prescriber must acknowledge this is a high risk medication (HRM) [as identified by American Geriatric Society] and medication benefits outweigh potential risk for this individual.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Opsumit

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	Individual is initiating therapy and has a diagnosis of clinically significant/severe anemia or in combination with other endothelin receptor antagonist (ERA) agents, such as but not limited to Letairis (ambrisentan) or Tracleer (bosentan).
Required Medical Information	Individual has catheterization-proven diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1) AND Individual has WHO Functional Class II-IV symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Orencia

Products Affected

- ORENCIA CLICKJECT MG/0.7ML
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML, 50 MG/0.4ML, 87.5

PA Criteria	Criteria Details
Exclusion Criteria	Using in combination with TNF antagonists or other biologic RA therapy, such as anakinra. Tuberculosis, other active serious infections or a history of recurrent infections. Individual has not had a tuberculin skin test (TST) or Centers for Disease Control (CDC)-recommended equivalent to evaluate for latent tuberculosis.
Required Medical Information	
Age Restrictions	For RA, Patient is 18 years of age or older. For JIA, Patient is 2 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For RA, Individual has had an inadequate response to ONE conventional therapy [non-biologic DMARD (such as methotrexate, sulfasalazine, leflunomide, or hydroxychloroquine)] or a tumor necrosis factor (TNF) antagonist AND has had a trial and inadequate response or intolerance to Humira (adalimumab) OR Enbrel (etanercept). For PsA, individual has had an inadequate response to ONE conventional therapy [nonbiologic DMARDs (such as methotrexate, sulfasalazine, or leflunomide)] or a tumor necrosis factor antagonist AND has had a trial and inadequate response or intolerance to Humira (adalimumab) OR Enbrel (etanercept). For JIA, Individual has had an inadequate response to, is intolerant of, or has a contraindication to ONE conventional Therapy [non-biologic DMARD such as methotrexate)] or a TNF antagonist AND has had a trial and inadequate response or intolerance to Humira (adalimumab) OR Enbrel (etanercept). For any of the above indications, if the TNF agent (Enbrel(etanercept)/Humira(adalimumab)) tried and failed are not acceptable due to concomitant clinical conditions, such as but not limited to any of the following: (a) Known hypersensitivity or any active or inactive component which is not also associated with Orencia or (b) Individual's age or (c) Pregnant or planning or becoming pregnant or (d) Serious infections or concurrent sepsis OR mbr has either concomitant clinical condition: (a) Demyelinating disease or (b) Heart failure with documented left ventricular dysfunction, Orencia may be allowed without trial of preferred TNF agents (Enbrel(etanercept)/Humira(adalimumab)).
Indications	All Medically-accepted Indications.
Off Label Uses	

Orenitram

Products Affected

- ORENITRAM

PA Criteria	Criteria Details
Exclusion Criteria	Moderate (child-Pugh Class B) or severe hepatic impairment (Child Pugh Class C). Using in combination with other treprostinil dosage forms (SQ, IV, and inhalation) unless transitioning from one dose form to another. Using in combination with other prostacyclin analogs [such as but not limited to epoprostenol (Flolan, Veletri, Ventavis (iloprost)] or prostacyclin receptor agonists [such as but not limited to Uptravi (selexipag)].
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Orfadin

Products Affected

- *nitisinone*
- ORFADIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual's plasma tyrosine level is maintained below 500 micromol/L to reduce risk of ocular symptoms, developmental delay, or hyperkeratotic plaques.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Orkambi

Products Affected

- ORKAMBI ORAL PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Mutation testing confirms (verbal or written) the individual has two copies of the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	Individual is 2 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Otezla

Products Affected

- OTEZLA ORAL TABLET
- OTEZLA ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is unable to take biologic agent due to product warning or contraindication for any of the following: Serious infection or sepsis, Chronic or recurrent infection, Tuberculosis infection, OR Malignancy. For plaque psoriasis (Ps) involves greater than five percent (5%) body surface area (BSA) or involves less than or equal to five percent (5%) BSA involving sensitive areas or areas that significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For Psoriatic Arthritis (PsA), Individual has had an inadequate response to, is intolerant of, or has a contraindication to conventional therapy [nonbiologic DMARDS (such as methotrexate, sulfasalazine, leflunomide)] AND individual has had a trial and an inadequate response or is intolerant to: Humira (adalimumab) OR Enbrel (etanercept). For plaque psoriasis (Ps), Individual has had an inadequate response to, is intolerant of, or has a contraindication to phototherapy or other systemic therapy (such as acitretin, cyclosporine or methotrexate) AND individual has had a trial and an inadequate response or is intolerant to: Humira (adalimumab) OR Enbrel (etanercept). For any of the above indications, if the TNF agent (Enbrel(etanercept)/Humira(adalimumab)) tried and failed are not acceptable due to concomitant clinical conditions, such as but not limited to any of the following: (a) Known hypersensitivity or any active or inactive component which is not also associated with Otezla or (b) Individual's age or (c) Pregnant or planning or becoming pregnant or (d) Serious infections or concurrent sepsis.
Indications	All Medically-accepted Indications.
Off Label Uses	

Oxandrin

Products Affected

- *oxandrolone oral tablet 10 mg, 2.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Carcinoma of the prostate or breast in male individuals OR Carcinoma of the breast in females with hypercalcemia. Using to enhance athletic performance or physique. Individual has a diagnosis of nephrosis (nephrotic phase of nephritis). Individual has a diagnosis of hypercalcemia.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

OxyContin

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Individual is requesting or using as an as-needed analgesic OR Individual has one of the following conditions: (a) Significant respiratory depression OR (b) Acute or severe bronchial asthma or hypercarbia OR (c) Known or suspected paralytic ileus.
Required Medical Information	
Age Restrictions	Individual is 11 years of age or older
Prescriber Restrictions	
Coverage Duration	Initial 3 months. Maintenance 6 months. Cancer Pain/Terminal Dx or Palliative Care 1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use, Individual has one of the following: (a) Diagnosis of cancer related pain and/or is actively undergoing cancer therapy (provide cancer diagnosis) OR (b) Diagnosis of terminal illness and is receiving palliative/end-of-life care (provide terminal diagnosis) OR Individual has pain severe enough to require daily, around-the-clock, long term opioid treatment (provide diagnosis) AND Individual has one of the following: (a) An inadequate response to ONE alternative treatment options, such as but not limited to non-opioid analgesics and immediate-release opioids OR (b) Alternative treatment options would otherwise be inadequate to provide sufficient management of pain OR (c) Individual has contraindications to non-opioid analgesics (such as NSAID use in individuals with active ulcer condition/gastrointestinal bleeding, renal failure). Individual is not opioid naïve as noted by the following: (a) Individual is currently using a short-acting opioid analgesic, including use of opioid analgesia as an inpatient for post-surgical pain OR (b) Individual is transitioning from one long-acting opioid analgesic to another long-acting opioid analgesic OR (c) already receiving and tolerating a minimum daily opioid dose of at least 20mg oxycodone orally or its equivalent. For continued use, Attestation (verbal or written) that long-acting opioid therapy has provided meaningful improvement in pain and/or function compared to baseline AND Prescriber has consulted with individual regarding risks of opioid therapy AND Clear treatment goals have been defined and outlined as part of overall plan.
Indications	All Medically-accepted Indications.
Off Label Uses	

Pegfilgrastim Agents

Products Affected

- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individuals who are at high risk for infection-associated complications by any of the following: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10 to the power of 9/L) neutropenia, Age greater than 65 years, Pneumonia or other clinically documented infections, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, Prior episode of febrile neutropenia, Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than 20% based on chemotherapy in patients who have risk factors for FN including any of the following: Individual age greater than 65 years, Poor performance status (ECOG status 3-4), Prior chemotherapy or radiation therapy, Bone marrow involvement by tumor producing cytopenias, persistent neutropenia (ANC less than 1500mm3), poor renal function (GFR less than 60mL/min) , liver dysfunction, recent surgery and or presence of open wounds.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.

PA Criteria	Criteria Details
Other Criteria	Individual with nonmyeloid malignancy is using for Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. Adjunctive use in neutropenic patients who are at high risk for infection-associated complications. In an individual with acute lymphocytic leukemia (ALL) after completion of the first few days of initial induction chemotherapy or first post-remission course of chemotherapy. For use after accidental or intentional total body radiation of myelosuppressive doses (greater than 2 Grays [Gy]) (such as Hematopoietic Syndrome of Acute Radiation Syndrome). For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for adjuvant treatment of breast cancer. After a hematopoietic progenitor stem cell transplant (HPCT/HSCT) to promote myeloid reconstitution OR when engraftment is delayed or has failed.
Indications	All Medically-accepted Indications.
Off Label Uses	

Piqray

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has confirmed (written or verbal attestation is acceptable) PIK3CA mutation using an FDA-approved test (such as the therascreen PIK3CA RGQ PCR Kit).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Pomalyst

Products Affected

- POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Praluent

Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off Label Uses	Pending CMS Review

Prolia

Products Affected

- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Osteoporosis is defined as a BMD T-Score of less than or equal to -2.5 OR a clinical diagnosis based on a history of a low trauma fracture (fragility fracture) at high risk for fracture. Risk factors for osteoporotic fracture is defined as: Hypogonadism or premature ovarian failure, Low body mass, Smoking, Rheumatoid arthritis, Alcohol intake of 3 or more drinks/day, Vitamin D deficiency, Low calcium intake, Hyperkyphosis, Parental hip fracture, Multiple falls, Medication: Anticoagulants, anticonvulsants, aromatase inhibitors, cancer chemotherapeutic drugs, gonadotropin-releasing hormone agonists, (glucocorticoid daily dosage equivalent to 5 mg or greater of prednisone for at least 3 months). Glucocorticoid-induced osteoporosis defined as a T score -2.5 or less and is initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5mg or greater of prednisone and expected or remain on glucocorticoids for a least 6 months.
Age Restrictions	For Osteoporosis 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For osteoporosis/ glucocorticoid-induced osteoporosis treatment, individual has had at least ONE osteoporotic (minimal trauma) fracture OR has two or more risk factors for osteoporotic fracture OR Individual has failed or is intolerant to or has a medical contraindication to other available osteoporosis therapies (such as, bisphosphonates). For male receiving androgen deprivation therapy for non- metastatic prostate cancer, individual has had at least ONE osteoporotic (minimal trauma) fracture OR has one or more risk factors for osteoporotic fracture. Individual is a postmenopausal (natural or induced) female receiving adjuvant aromatase inhibitor therapy for the treatment of breast cancer.
Indications	All Medically-accepted Indications.
Off Label Uses	

Promacta

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Using Promacta to normalize platelet counts. Use in individuals with ITP whose degree of thrombocytopenia and clinical condition (for example, platelet count greater than 30 x 109/L or active bleeding) do not increase the risk of bleeding. Use in individuals with chronic hepatitis C whose degree of thrombocytopenia does not prevent the initiation of peginterferon therapy or limits the ability to maintain an optimal peginterferon-based therapy. Used in individuals with chronic hepatitis C who are no longer on a peginterferon and ribavirin based regimen. Used concomitantly with other thrombopoietin receptor agonists such as romiplostim (Nplate). Used in individuals taking in combination with direct-acting antiviral agents used without concomitant use of a peginterferon agent for treatment of thrombocytopenia associated with chronic hepatitis C infection.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For initial therapy: 1) Diagnosis of chronic immune (idiopathic) thrombocytopenia (ITP) AND individual has platelet count of less than 30 x 109/L or active bleeding (ASH, 2011. Hicks et al., 2014) AND has had a prior trial and insufficient response to one of the following: a) corticosteroids or b) immunoglobulins [for example, intravenous, anti-D] or c) splenectomy. OR, 2) Diagnosis of severe aplastic anemia AND individual has a platelet count of less than or equal to 30 x 109/L (Olnes et al., 2012.Desmond et al., 2014) AND individual has had a prior trial and insufficient response to an immunosuppressive therapy [such as, anti-thymocte globulin (ATG)]. OR 3) dx of severe aplastic anemia AND is being used in combination with standard immunosuppressive therapy for first-line treatment. For maintenance therapy, individual has demonstrated a response to therapy as evidenced by increased platelet counts AND to maintain an adequate platelet count (50 - 200 x 109/L) to decrease the risk of bleeding.
Indications	All Medically-accepted Indications.
Off Label Uses	

Protopic

Products Affected

- *tacrolimus external*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual had a trial of and inadequate response or intolerance to one topical prescription strength corticosteroid.
Indications	All Medically-accepted Indications.
Off Label Uses	

Purixan

Products Affected

- PURIXAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

quinine

Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
Exclusion Criteria	Treatment or prevention for nocturnal recumbancy leg muscle cramps or related conditions such as but not limited to: Leg cramps, muscle cramps, myoclonus, Periodic Movements of Sleep, Periodic Limb Movements of Sleep (PLMS), Restless Leg Syndrome (RLS), severe hepatic impairment (Child-Pugh C), known prolongation of the QT interval, initial treatment of severe or complicated P. falciparum malaria, prevention of malaria, individuals with glucose-6-phosphate dehydrogenase (G6PD) deficiency, individuals with myasthenia gravis, or individuals with optic neuritis .
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has been diagnosed with uncomplicated malaria caused by one of the following: Plasmodium falciparum known or suspected to be resistant to chloroquine (CDC 2013) OR chloroquine-resistant Plasmodium vivax (CDC 2013) OR an unidentified plasmodial species known or suspected to be resistant to chloroquine (CDC 2013).
Indications	All Medically-accepted Indications.
Off Label Uses	

Ravicti

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	Using for the management of acute hyperammonemia. Using to treat N-acetylglutamate synthase deficiency (NAGS).
Required Medical Information	
Age Restrictions	2 months of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has had a trial and inadequate response or intolerance to sodium phenylbutyrate (Buphenyl) OR Individual has any of the following: (a) Congestive heart failure or (b) Severe renal insufficiency or (c) A clinical state where there is sodium retention with edema.
Indications	All Medically-accepted Indications.
Off Label Uses	

Regranex

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	Individual is using as adjunctive therapy with good ulcer care practices including, but not limited to sharp debridement of the ulcer
Indications	All Medically-accepted Indications.
Off Label Uses	

RELISTOR

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Individual has a known or suspected mechanical gastrointestinal obstruction.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual must have a previous trial of or insufficient response to polyethylene glycol (generic MiraLax) (AGA 2013) AND a trial and inadequate response or intolerance to a preferred agent (Movantik/Amitiza) OR the preferred agent (Movantik/Amitiza) is not acceptable due to concomitant clinical situations, warnings or contraindications, such as but not limited to the following: (1) individual is taking a diphenylheptane opioid (e.g., methadone), where effectiveness has not been established in the treatment of OIC (Amitiza) OR (2) individual has disruption to the blood-brain barrier and may be at increased risk for opioid withdrawal and/or reduced analgesia (Movantik) OR (3) individual is taking strong CYP3A4 inhibitors and may be at increased risk for opioid withdrawal and/or reduced analgesia (Movantik).
Indications	All Medically-accepted Indications.
Off Label Uses	

Repatha

Products Affected

- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off Label Uses	Pending CMS Review

Restasis

Products Affected

- RESTASIS
- RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 %

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation is provided indicating an abnormal result or response to one or more of the following dry eye disease diagnostic/assessment methods (AAO, 2018): (a) Tear break-up time (less than 10 seconds) OR (b) Ocular surface dye staining using fluorescein, rose bengal, or lissamine green dyes OR (c) Schirmer test (aqueous tear production of less than or equal to 10 mm of strip wetting in 5 minutes) OR (d) Fluorescein clearance test/tear function index OR (e)Tear osmolarity (indicating tear film instability) OR (f) Tear lactoferrin concentrations in the lacrimal gland (decreased) OR (g) Matrix metalloproteinase-0 (MMP-9) test.
Age Restrictions	16 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	Individual is using to treat moderate to severe dry eye disease (AAO 2018) AND Individual has had a trial and inadequate response or intolerance to Xiidra (lifitegrast) OR Individual has a known hypersensitivity to any ingredient in the preferred agent (Xiidra) which is not also present in the requested non-preferred agent.
Indications	All Medically-accepted Indications.
Off Label Uses	

Revatio

Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Use in combination with phosphodiesterase-5 (PDE5) inhibitors [such as but not limited to, Viagra (sildenafil)]. Use in combination with organic nitrates, such as but not limited to, isosoribide mono/dinitrate or nitroglycerin. Use in combination with guanylate cyclase stimulators [such as but not limited to, Adempas (riociguat)]. Use in individuals requesting for the treatment of erectile dysfunction. Use in individuals with severe hepatic impairment (Child-Pugh Class C). Use in individual has a diagnosis of pulmonary veno-occlusive disease (PVOD). Use in individual has a known hereditary degenerative retinal disorder (such as but not limited to, retinitis pigmentosa).
Required Medical Information	Catheterization-proven diagnosis of Pulmonary Arterial Hypertension (PAH) World Health Organization (WHO Group I) and WHO Functional Class II-IV symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Revlimid

Products Affected

- REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Rexulti

Products Affected

- REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Rozlytrek

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For metastatic non-small cell lung cancer (NSCLC), 18 years of age or older. For a diagnosis of a solid tumor, 12 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For solid tumors, the individual has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation with confirmed genetic test results.
Indications	All Medically-accepted Indications.
Off Label Uses	

Rubraca

Products Affected

- RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For epithelial ovarian, fallopian tube, or primary peritoneal cancer, Individual has confirmed deleterious BRCA mutation (verbal or written).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Ruconest

Products Affected

- RUCONEST

PA Criteria	Criteria Details
Exclusion Criteria	Individual is using for prophylaxis or in individuals with laryngeal attacks.
Required Medical Information	Hereditary Angioedema (HAE) is confirmed by a C4 level below the lower limit of normal as defined by the laboratory performing the test AND ONE of the following (a or b): a) C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test OR b) C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test AND Individual has a history of moderate or severe attacks (for example, airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion).
Age Restrictions	13 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Rydapt

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Sabril

Products Affected

- SABRIL ORAL TABLET
- *vigabatrin*
- *vigadrone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For infantile spasm 1 month to 2yr old. For seizure 10 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Seroquel Line

Products Affected

- *quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For schizophrenia, 13 years of age or older. For bipolar disorder, 10 years of age or older. For MDD, 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For schizophrenia/bipolar use, the individual has had a trial of one of the following generic oral atypical antipsychotic: Risperidone, Olanzapine, Quetiapine fumarate, Paliperidone, Aripiprazole or Ziprasidone.
Indications	All Medically-accepted Indications.
Off Label Uses	

Signifor IR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	Individual has a diagnosis of severe hepatic impairment (Child-Pugh C)
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

SIMPONI

Products Affected

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML

PA Criteria	Criteria Details
Exclusion Criteria	Using golimumab in combination with other TNF antagonists, JAK inhibitors, or other biologic drugs (such as, abatacept, anakinra, or vedolizumab). Tuberculosis, other active serious infections, or a history of recurrent infections. Individuals who have not had a TST or a CDC-recommended equivalent to evaluate for latent tuberculosis prior to initiating Simponi (golimumab).
Required Medical Information	
Age Restrictions	Individual is 18 years or older
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For RA, individual has had an inadequate response to, is intolerant of, or has a medical contraindication to ONE Conventional Therapy [non-biologic DMARD (such as methotrexate, sulfasalazine, leflunomide, or hydroxychloroquine)] (ACR 2015) AND individual has had a trial of and inadequate response or intolerance to: Humira (adalimumab) OR Enbrel (etanercept). For Psoriatic Arthritis, individual has had an inadequate response to, is intolerant of, or has a medical contraindication to ONE conventional therapy [nonbiologic DMARDs (such as methotrexate, sulfasalazine, or leflunomide)] AND individual has had a trial of and an inadequate response or intolerance to Humira(adalimumab) OR Enbrel(etanercept). For Ankylosing Spondylitis, had an inadequate response to, is intolerant of, or has a medical contraindication to ONE conventional therapy (e.g. NSAIDs or nonbiologic DMARDs) AND individual has had a trial of and an inadequate response or intolerance to: Humira(adalimumab) OR Enbrel(etanercept). For UC, individual has had an inadequate response, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as 6-mercaptopurine, azathioprine, oral aminosalicylates, or oral corticosteroids) AND individual has had a trial of and an inadequate response or is intolerant to Humira(adalimumab). For any of the above indications, if the TNF agent (Enbrel(etanercept)/Humira(adalimumab)) tried and failed are not acceptable due to concomitant clinical conditions, such as but not limited to any of the following: (a) Known hypersensitivity or any active or inactive component which is not also associated with Simponi or (b) Individual's age or (c) Pregnant or planning or becoming pregnant or (d) Serious infections or concurrent sepsis. Simponi may be allowed without trial of preferred TNF agents (Enbrel(etanercept)/Humira(adalimumab)).
Indications	All Medically-accepted Indications.
Off Label Uses	

Sirturo

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	Latent infection due to Mycobacterium tuberculosis OR Drug-sensitive tuberculosis OR Extra-pulmonary tuberculosis OR Infections caused by non-tuberculosis mycobacteria.
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of pulmonary multi-drug resistant tuberculosis AND is unable to use an effective regimen for treatment AND the individual is using Sirturo (bedaquiline) with at least 3 drugs to which the multi-drug resistant tuberculosis isolate is susceptible in vitro OR with at least 4 drugs to which the multi-drug resistant tuberculosis isolate is likely to be susceptible if in vitro testing results are unavailable.
Indications	All Medically-accepted Indications.
Off Label Uses	

Solaraze

Products Affected

- *diclofenac sodium transdermal gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dx of Actinic Keratosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Somatuline Depot

Products Affected

- SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML, 90 MG/0.3ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Somavert

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dx of acromegaly AND member has had an inadequate response to surgery and/or radiation OR Surgery and/or radiation therapy are not an option.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Spravato

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Initial 3 months, continuation 1 year.
Other Criteria	For initial use, individual has been diagnosed with moderate to severe major depressive disorder AND had an inadequate response to the maximum tolerated dose of two antidepressant therapies during the current major depressive episode (MDE) as defined by less than 50% reduction in symptom severity using a standard rating scale that reliably measures depressive symptoms AND will use Spravato in addition to antidepressant therapy. For continuation, individual has had at least a 50% reduction in symptoms of depression compared to baseline using a standard rating scale that reliably measures depressive symptoms AND will use Spravato in addition to antidepressant therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

Spritam

Products Affected

- SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG, 750 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has a diagnosis of partial onset seizures OR primary generalized tonic-clonic seizures AND weighs more than 20 kg.
Age Restrictions	Partial onset seizures: 4 years old. Juvenile myoclonic epilepsy: 12 years old. Primary generalized tonic-clonic seizures: 6 years old.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Sprycel

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Written or verbal attestation is provided for confirmation of mutations where applicable based on use/diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Stelara

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Known to have reversible posterior leukoencephalopathy syndrome (RPLS) while on tx with Stelara. Individual has not had a tuberculin skin test (TST) or a Centers for Disease Control (CDC) and Prevention-recommended equivalent test to evaluate for latent tuberculosis prior to initiating Stelara (ustekinumab). Individual has tuberculosis, other active serious infections or a history of recurrent infections. Using ustekinumab in combination with phototherapy. In combination with JAK inhibitors or other biologic drugs (such as TNF antagonists).
Required Medical Information	Diagnosis of moderate to severe plaque psoriasis with either of the following: Patient has greater than 5% of body surface area with plaque psoriasis OR Less than or equal to 5% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	Individual is 18 years of age or older. For Plaque Psoriasis, age 12 and older.
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For chronic plaque psoriasis, individual has had an inadequate response to, is intolerant of, or has a medical contraindication to phototherapy or any ONE systemic therapy (for example acitretin, methotrexate, cyclosporine) AND individual has had a trial of and an inadequate response or is intolerant to Humira (adalimumab) or Enbrel (etanercept). For psoriatic arthritis, individual has had an inadequate response to, is intolerant of, or has a medical contraindication to ONE conventional therapy ([nonbiologic DMARDS] such as methotrexate, sulfasalazine, or leflunomide) AND individual has had a trial of and an inadequate response or is intolerant to Humira (adalimumab) or Enbrel (etanercept). For Crohns disease, individual has had an inadequate response to, has lost response to, is intolerant of, or has a medical contraindication to conventional therapy (such as 5-Aminosalicylic acid products, systemic corticosteroids, or immunosuppressants) or a tumor necrosis factor (TNF) antagonist AND individual has had a trial and inadequate response or intolerance to Humira (adalimumab). For any of the above indications, if the TNF agent (Enbrel(etanercept)/Humira(adalimumab)) tried and failed are not acceptable due to concomitant clinical conditions, such as but not limited to any of the following: (a) Known hypersensitivity or any active or inactive component which is not also associated with Stelara or (b) Individual's age or (c) Pregnant or planning or becoming pregnant or (d) Serious infections or concurrent sepsis OR individual has either concomitant clinical condition: (a) Demyelinating disease or (b) Heart failure with documented left ventricular dysfunction, Stelara may be allowed without trial of preferred TNF agents (Enbrel(etanercept)/Humira(adalimumab)). For Crohns, if the TNF agent tried and failed are not acceptable due to additional concomitant clinical conditions including: (c) Malignancy [such as but not limited to, solid or hematologic cancers and excluding superficial skin cancers (such as basal and squamous cell)] or (d) Tuberculosis infection.
Indications	All Medically-accepted Indications.
Off Label Uses	

Stivarga

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Sutent

Products Affected

- SUTENT ORAL CAPSULE 12.5 MG, 25 MG, 37.5 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Sylatron

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Member is being treated for melanoma with microscopic or gross nodal involvement AND Treatment is initiated within 84 days after definitive surgical resection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Symlin

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	May not be approved if individual has any of the following: receiving drugs that stimulate gastric motility (i.e. metoclopramide), diagnosis of severe gastroparesis, hypoglycemia unawareness or recent hypoglycemia requiring assistance within past 6 months
Required Medical Information	Type 1 or type 2 diabetes AND taking mealtime insulin therapy AND failed to achieve glucose control AND HBA1C is less than or equal to 9.
Age Restrictions	18 or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Synarel Nasal Solution

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Precocious puberty, defined as the beginning of secondary sexual maturation characteristics before age 8 in girls and before age 9 in boys.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Endometriosis: 6 months, all other indications: 1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Synribo

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Tafinlar

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Exclusion Criteria	Tafinlar may not be approved for the treatment of individuals with wild type BRAF melanoma.
Required Medical Information	BRAF V600E or V600K mutation results must be confirmed (verbal or written).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Tagrisso

Products Affected

- TAGRISSO ORAL TABLET 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has either: (a) EGFR (epidermal growth factor receptor) T790M mutation is confirmed (verbal or written) OR (b) EGFR exon 19 deletions or exon 21 L858R mutations is confirmed (verbal or written)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Talzenna

Products Affected

- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Written or verbal attestation provided to confirm deleterious or suspected deleterious germline BRCA-mutation (gBRCAm) and human epidermal growth factor receptor 2-negative (HER2) breast cancer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Tarceva

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC tumors that have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations, a copy of the test results must be provided
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Targretin

Products Affected

- *bexarotene*
- TARGRETIN EXTERNAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Tasigna

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Tasmar

Products Affected

- *tolcapone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Tazorac

Products Affected

- *tazarotene external*
- TAZORAC EXTERNAL CREAM 0.05 %
- TAZORAC EXTERNAL GEL

PA Criteria	Criteria Details
Exclusion Criteria	May not be approved for cosmetic purposes such as, but not limited to the following: Photoaging, Wrinkles, Hyperpigmentation, Sun damage, or Melasma.
Required Medical Information	For psoriasis, individual has up to 20% of body surface area involvement.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For psoriasis, individual has had a prior trial and inadequate response to either of the following (AAD 2009): Any two (2) topical corticosteroids or any one (1) topical corticosteroids plus calcipotriene. For psoriasis use greater than 1 year, efficacy must be documented for continued use. Documentation may include chart notes, consultation notes.
Indications	All Medically-accepted Indications.
Off Label Uses	

Tecentriq

Products Affected

- TECENTRIQ INTRAVENOUS SOLUTION 1200 MG/20ML, 840 MG/14ML

PA Criteria	Criteria Details
Exclusion Criteria	Individual has received treatment with another PD-1 agent or PD-L1 (for example, nivolumab or pembrolizumab) and Individual is receiving therapy for an autoimmune disease or chronic condition requiring treatment with a systemic immunosuppressant.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For locally advanced or metastatic urothelial carcinoma, has a current Eastern Cooperative Oncology Group (ECOG) performance status of 0-2. For metastatic non-small cell lung cancer (NSCLC), extensive-stage small cell lung cancer has a current Eastern Cooperative Oncology Group (ECOG) performance status of 0-2.
Indications	All Medically-accepted Indications.
Off Label Uses	

Tecfidera

Products Affected

- TECFIDERA

PA Criteria	Criteria Details
Exclusion Criteria	Using in combination with other immunomodulatory products (such as Aubagio, Gilenya, Tysabri, Copaxone/Glatopa, Extavia, Rebif, Avonex, Plegridy, Lemtrada, Ocrevus or Betaseron).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Testosterone Inj

Products Affected

- *testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml*
- *testosterone enanthate intramuscular solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For initial use of replacement therapy, Individual has a dx of (1) primary hypogonadism (congenital or acquired) such as but not limited to: Cryptorchidism OR Bilateral torsion OR Vanishing testis syndrome OR orchitis OR Orchiectomy OR Klinefelter Syndrome OR Chemotherapy OR Toxic damage from alcohol or heavy metals OR idiopathic primary hypogonadism. Or (2) Hypogonadotropic hypogonadism (congenital or acquired), such as but not limited to: Idiopathic luteinizing hormone-releasing hormone (LHRH deficiency) OR Pituitary-hypothalamic injury AND Individual presents with symptoms associated with hypogonadism, such as but not limited to, at least one of the following: (a) Reduced sexual desire (libido) and activity or (b) Decreased spontaneous erections or (c) Breast discomfort/gynecomastia or (d) Loss of body (axillary and pubic) hair, reduced need for shaving or (e) Very small (especially less than 5 mL) or shrinking testes or (f) Inability to father children or low/zero sperm count or (g) Height loss, low trauma fracture, low bone mineral density or (h)Hot flushes, sweats or (i) Other less specific signs and symptoms including decreased energy, depressed mood/dysthymia, irritability, sleep disturbance, poor concentration/memory, diminished physical or work performance. For Continuation of Testosterone Inj agents for replacement therapy, (a) Individual met all diagnostic criteria for initial therapy and (b) Individual has had serum testosterone level measured in the previous 180 days and (c) Individual has obtained clinical benefits as noted by symptom improvement. For treatment of delayed puberty when ALL the criteria below are met: Individual is using to stimulate puberty and individual has few to no signs of puberty. For treatment of breast cancer when the following are met: Female 1-5 years post-menopause and Individual is using secondarily for advanced inoperable metastatic (skeletal) breast cancer OR Premenopausal female who has benefited from oophorectomy and is considered to have a hormone responsive tumor. For treatment of HIV-infected male adults with low testosterone and HIV-associated weight loss and wasting. For transgender individuals who meet ALL the following criteria:
	Individual has a diagnosis of gender dysphoria or gender identity disorder and goal of treatment is female-to-male gender reassignment.
Indications	All Medically-accepted Indications.
Off Label Uses	

Thalomid

Products Affected

- THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Tibsovo

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented susceptible isocitrate dehydrogenase-1 (IDH1) (written or verbal attestation is acceptable)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Topical Androgens

Products Affected

- *testosterone transdermal gel 1.62 %, 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 40.5 mg/2.5gm (1.62%)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older. For transgender use, individual is 16 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has a dx of (1) primary hypogonadism (congenital or acquired) [for example, Cryptorchidism OR Bilateral torsion OR orchitis OR Vanishing testis syndrome OR Orchiectomy OR Klinefelter Syndrome OR Chemotherapy OR Toxic damage from alcohol or heavy metals OR idiopathic primary hypogonadism]. Or (2) Hypogonadotropic hypogonadism (congenital or acquired) [for example, Idiopathic luteinizing hormone-releasing hormone (LHRH deficiency), OR Pituitary-hypothalamic injury.] Individual is transgender AND is using for a diagnosis of gender Dysphoria or gender Identity Disorder AND Goal of treatment is female-to-male gender reassignment.
Indications	All Medically-accepted Indications.
Off Label Uses	

Topical Tretinoin Agents

Products Affected

- *avita*
- *tretinoin external cream*
- *tretinoin external gel 0.01 %, 0.025 %*
- *tretinoin microsphere*
- *tretinoin microsphere pump*

PA Criteria	Criteria Details
Exclusion Criteria	Topical tretinoin agents may not be approved for cosmetic purposes such as, but not limited to the following: Photoaging, Wrinkles, Hyperpigmentation, Sun damage, Melasma.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Tracleer

Products Affected

- *bosentan*
- TRACLEER ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Exclusion Criteria	Individual is concomitantly taking cyclosporine A or glyburide. Individual has a diagnosis of moderate (Child-Pugh Class B) or severe (Child-Pugh Class C) hepatic impairment or in the treatment of congestive heart failure with left ventricular dysfunction. Or Individual is initiating therapy and has elevated [greater than 3 times the upper limit of normal (ULN)] baseline aminotransferase levels OR In combination with other endothelin receptor antagonist (ERA) agents, such as but not limited to Letairis (ambrisentan) or Opsumit (macitentan).
Required Medical Information	Catheterization-proven diagnosis of Pulmonary Arterial Hypertension (WHO Group I), and WHO Functional Class II-IV symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Trelstar Line

Products Affected

- TRELSTAR MIXJECT
  INTRAMUSCULAR SUSPENSION
  RECONSTITUTED 11.25 MG, 3.75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7/Gleason grade group 2-3, or prostate specific antigen (PSA) value of 10-20 ng/mL) OR higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR Following radical prostatectomy as adjuvant therapy when lymph node metastases are present OR Locally advanced disease OR Other advanced, recurrent, or metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Turalio

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Tykerb

Products Affected

- TYKERB

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cancer has been confirmed HER2 positive
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Uceris

Products Affected

- *budesonide er oral tablet extended release 24 hour*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Uptravi

Products Affected

- UPTRAVI ORAL TABLET
- UPTRAVI ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	Individual has a diagnosis of severe hepatic impairment (Child-Pugh Class C). In combination with prostacyclin analogs [such as but not limited to treprostinil (Orenitram, Remodulin, Tyvaso), Epoprostenol (Flolan, Veletri), Ventavis (iliprost)]
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has catheterization-proven diagnosis of pulmonary arterial hypertension (PAH) [World Health Organization (WHO) Group 1) AND individual has WHO functional class II-IV symptoms.
Indications	All Medically-accepted Indications.
Off Label Uses	

Valchlor

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Vancocin

Products Affected

- *vancomycin hcl oral capsule 125 mg, 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is being treated for enterocolitis caused by Staphylococcal aureus including methicillin-resistant strains. Individual is being treated for clostridium difficile.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Velcade

Products Affected

- BORTEZOMIB

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Vemlidy

Products Affected

- VEMLIDY

PA Criteria	Criteria Details
Exclusion Criteria	Individual has end stage renal disease (estimated creatinine clearance below 15 mL/min). Individual has decompensated (Child-Pugh B or C) hepatic impairment
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Venclexta

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Ventavis

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnostic Criteria for PAH: right heart catheterization which shows a mean pulmonary artery pressure (mPAP) greater than or equal to 25mmhg, a pulmonary capillary wedge pressure (PCWP), left atrial pressure or left ventricular end diastolic pressure (LVEDP) less than or equal to 15mmhg AND a pulmonary vascular resistance (PVR) greater than 3 wood units. Criteria for Vasodilator Response: a favorable response is defined as a fall in mPAP of at least 10mmhg to an absolute mPAP of less than 40mmhg without a decrease in cardiac output, when challenged with inhaled nitric oxide, intravenous epoprostenol or intravenous adenosine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For Ventavis, patient must meet all of the following: meets diagnostic criteria for PAH AND demonstrates an unfavorable acute response to vasodilators AND Individual has New York Heart Association (NYHA) functional class III, or IV symptoms: AND World health Organization (WHO) Group I PAH (idiopathic PAH, PAH associated with connective tissue disorders, PAH associated with congenital heart defects, and all Group 1 subtypes).
Indications	All Medically-accepted Indications.
Off Label Uses	

Verzenio

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Vfend

Products Affected

- *voriconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is currently transitioning from inpatient treatment (hospital/medical facility) with IV antifungal (voriconazole) to an outpatient (home) setting.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

VIBERZI

Products Affected

- VIBERZI

PA Criteria	Criteria Details
Exclusion Criteria	Individual has a history of severe constipation or sequelae from constipation OR Biliary duct obstruction or sphincter of Oddi dysfunction OR History of pancreatitis or structural disease of the pancreas OR Excessive alcohol intake (more than 3 alcoholic beverages per day) OR Severe hepatic impairment (Child-Pugh Class C) OR Concomitant use with Lotronex (alosetron) OR history of cholecystectomy or absence of a gallbladder.
Required Medical Information	
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	Individual is using for the treatment of irritable bowel syndrome with diarrhea (IBS-D) AND has had a trial and inadequate response or intolerance to two of the following medications or has a contraindication to all of the following medications: 1. Loperamide OR 2. Antispasmodics (such as dicyclomine) OR 3. Tricyclic antidepressants (AGA 2014).
Indications	All Medically-accepted Indications.
Off Label Uses	

Vitrakvi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Written or verbal attestation to confirm genetic test results show the tumor has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Vivitrol

Products Affected

- VIVITROL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For alcohol dependence, Individual is not actively drinking at the time of initial injectable naltrexone (Vivitrol) administration AND is able to abstain from alcohol for at least 7 days in an outpatient setting prior to treatment initiation AND is not actively drinking at the time of initial injectable naltrexone (Vivitrol) administration AND Agent is used as a part of a substance use disorder treatment program to include counseling and psychosocial support AND Individual is NOT currently on opioid analgesics OR not currently on opioid agonist for the treatment of opioid dependence (opioid use disorder) (for example buprenorphine and methadone) OR physiologically dependent on opioids OR currently in acute opioid withdrawal. Individual also does NOT have: a positive urine screen for opioids OR a failed naloxone challenge test OR acute hepatitis OR liver failure OR previous hypersensitivity to naltrexone, 75:25 polylactide-co-glycolide (PLG), carboxymethylcellulose or any other component of the diluent. For Opioid dependence, individual has successfully completed an opioid detoxification program AND has been opioid-free (including buprenorphine and methadone) for at least 7 days prior to initiating treatment with naltrexone (Vivitrol) injection AND Agent is used as a part of a substance use disorder treatment program to include counseling and psychosocial support AND is NOT currently on opioid analgesics for pain management OR currently in acute opioid withdrawal. Individual also does NOT have a positive urine screen for opioids OR a failed naloxone challenge test OR acute hepatitis OR liver failure OR previous hypersensitivity to naltrexone, 75:25 polylactide-co-glycolide (PLG), carboxymethylcellulose or any other component of the diluent.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Vizimpro

Products Affected

- VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	genetic mutations test result is confirmed by written or verbal attestation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

VOTRIENT

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Vytorin

Products Affected

- *ezetimibe-simvastatin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has had a trial of TWO generic statin (at any dose) and did not achieve LDL cholesterol goal OR Individual is currently on an agent that interacts with both preferred generics.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Xalkori

Products Affected

- XALKORI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation is provided that tumor is anaplastic lymphoma kinase (ALK)-positive or c-ros oncogene 1 (ROS1) positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Xeljanz

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	UUsing in combination with, other JAK inhibitors (such as Olumiant), biologic disease-modifying antirheumatic drug (DMARDs) (such as but not limited to, TNF agents, anti-CD20 monoclonal antibodies, IL-1R antagonists, selective co-stimulation modulators) or potent immunosuppressants such as azathioprine and cyclosporine. At initiation of therapy, absolute neutrophil count (ANC) less than 1000 cells/mm3, lymphocyte count less than 500 cells/mm3, or hemoglobin less than 9 g/dL. Tuberculosis or other active serious infections or a history of recurrent infections. Individual has not had a tuberculin skin test (TST) or a Centers for Disease Control (CDC)-recommended equivalent to evaluate for latent tuberculosis prior to initiating Xeljanz. Individual has severe hepatic impairment (Child Pugh class C).
Required Medical Information	
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For RA and PsA, Individual had an inadequate response to, is intolerant of, or has a contraindication to ONE conventional therapy [nonbiologic DMARDS (such as methotrexate, sulfasalazine, leflunomide, or hydroxychloroquine)] and individual has had a trial of and an inadequate response or is intolerant to: Humira(adalimumab) OR Enbrel(etanercept) OR the TNF agent (Enbrel(etanercept)/Humira(adalimumab)) tried and failed are not acceptable due to concomitant clinical conditions, such as but not limited to any of the following: (a) Known hypersensitivity or any active or inactive component which is not also associated with Xeljanz or (b) Individual's age or (c) Pregnant or planning or becoming pregnant or (d) Serious infections or concurrent sepsis. For UC, Individual had an inadequate response to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as 6-mercaptopurine, azathioprine, oral aminosalicylates, or oral corticosteroids) AND has had a trial of and an inadequate response or is intolerant to Humira (adalimumab) OR Humira (adalimumab) is not acceptable due to concomitant clinical conditions, such as but not limited to any of the following listed above (a-d).
Indications	All Medically-accepted Indications.
Off Label Uses	

XENAZINE

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Xermelo

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Initial: 3 months. Continuation: 1 year
Other Criteria	For initial therapy: Individual is using in combination with somtostatin analog (SSA) therapy (such as but not limited to, lanreotide(Somatuline Depot), cotreotide (Sandostatin)) AND individual has had an inadequate response on a stable dose of SSA monotherapy for at least 3 months. For continuation therapy: Individual has previously met the initiation criteria AND if clinically significant improvements are confirmed after 12 weeks pf treatment with Xermelo (telotristat ethyl) when added to SSA therapy
Indications	All Medically-accepted Indications.
Off Label Uses	

Xgeva

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Skeletally mature adolescent is defined by at least one mature long bone [for example, closed epiphyseal growth plate of the humerus]. Hypercalcemia of malignancy is defined as an albumin corrected serum calcium level greater than 12.5 mg/dL (3.1 mmol/L).
Indications	All Medically-accepted Indications.
Off Label Uses	

Xifaxan - HE

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Xifaxan 200mg

Products Affected

- XIFAXAN ORAL TABLET 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	For Xifaxan 200mg, travelers diarrhea (TD) caused by noninvasive strains of Escherichia coli AND Individual has already been started on Xifaxan and needs to complete treatment OR Individual has had a trial and inadequate response or intolerance to one of the following medications or has contraindications to all of the following medications (CDC, 2018): (1)Generic Fluoroquinolone OR(2)Azithromycin.
Indications	All Medically-accepted Indications.
Off Label Uses	

Xiidra

Products Affected

- XIIDRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation is provided indicating an abnormal result or response to one or more of the following dry eye disease diagnostic/assessment methods (AAO, 2018): (a) Tear break-up time (less than 10 seconds) OR (b) Ocular surface dye staining using fluorescein, rose bengal, or lissamine green dyes OR (c) Schirmer test (aqueous tear production of less than or equal to 10 mm of strip wetting in 5 minutes) OR (d) Fluorescein clearance test/tear function index OR (e)Tear osmolarity (indicating tear film instability) OR (f) Tear lactoferrin concentrations in the lacrimal gland (decreased) OR (g) Matrix metalloproteinase-9 (MMP-9) test.
Age Restrictions	17 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	Individual is using to treat moderate to severe dry eye disease (AAO 2018).
Indications	All Medically-accepted Indications.
Off Label Uses	

Xolair

Products Affected

- XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has Moderate to Severe Persistent Asthma AND has a positive skin test or in vitro reactivity to a perennial aeroallergen, AND individual has an FEV1 less than 80% predicted AND IgE level is equal to or greater than 30 IU/ml. Severe asthma as defined by the National Heart, Lung, and Blood Institute: Severe Persistent Asthma: symptoms throughout the day, extremely limited normal activity. Nocturnal symptoms are frequent, FEV1 or PEF is less than or equal to 60% predicted. Moderate Persistent Asthma as defined by the National Heart, Lung, and Blood Institute: Daily symptoms, daily use of inhaled short-acting beta2-agonist, somewhat limited activity, Nocturnal symptoms occur greater than 1 time per week, FEV1 or PEF is greater than 60% and less than 80% predicted, FEV1 FVC is reduced 5 percent or exacerbations requiring oral systemic corticosteroids use for more than or equal to 2 times per year.
Age Restrictions	Patient is 12 years of age or older for urticaria and 6 years of age or older for moderate to severe persistent asthma
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	For moderate to severe persistent asthma, individual has had a minimum of 3 month trial and inadequate response or intolerance to ONE combination controller therapy (medium to high doses of inhaled corticosteroids plus long acting beta-2 agonists or Leukotriene modifiers)(GINA 2018). Continued treatment beyond 12 months is allowed when treatment has resulted in clinical improvement as documented by one or more of the following: Decreased utilization of rescue medications OR Decreased frequency of exacerbations (defined as worsening of asthma that requires increase in inhaled corticosteroid dose or treatment with systemic corticosteroids) OR Increase in percent predicted FEV1 from pretreatment baseline OR Reduction in reported asthma-related symptoms, such as, but not limited to, wheezing, shortness of breath, coughing, fatigue, sleep disturbance, or asthmatic symptoms upon awakening. For chronic idiopathic urticaria, individual has had trial and inadequate response or intolerance to ONE potent antihistamine (AAAAI/ACAAI 2014).
Indications	All Medically-accepted Indications.
Off Label Uses	

Xospata

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has confirmed FMS-like tyrosine kinase 3 (FLT3) mutation (written or verbal attestation is acceptable).
Age Restrictions	18 years of age and older.
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Xpovio

Products Affected

- XPOVIO (100 MG ONCE WEEKLY)
- XPOVIO (60 MG ONCE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY)
- XPOVIO (80 MG TWICE WEEKLY)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Xtandi

Products Affected

- XTANDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy.
Indications	All Medically-accepted Indications.
Off Label Uses	

Xyrem

Products Affected

- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial tx of Narcolepsy type 1 (narcolepsy with cataplexy) confirmed by the presence of daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months and at least one of the following: (1) Clear cataplexy (defined as more than one episode of generally brief [less than 2 min]) usually bilaterally symmetrical, sudden loss of muscle tone with retained consciousness) AND (2) Multiple Sleep Latency Test (MSLT) showing one of the following: (a) MSLT of less than 8 minutes with evidence of two sleep-onset rapid eye movement periods (SOREMPs) (ICSD-3, 2014) or (b) At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) OR (3) Cerebrospinal fluid hypocretin-1 deficiency (less than 110 pg/mL or less than one-third of the normative values with the same standardized assay).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial Request 3 months, Renewal is 6 months.

PA Criteria	Criteria Details
Other Criteria	For initial tx, of Narcolepsy type 2 (narcolepsy without cataplexy) confirmed by the following: (1) Daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months AND (2) MSLT showing one of the following: (a) MSLT of less than 8 minutes with evidence of two SOREMPs (ICSD-3, 2014) or (b) At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight PSG AND (3) absence of cataplexy AND (4) Exclusion of alternative causes of excessive daytime sleepiness by history, physical exam and PSG. AND (5) Mbr has had a previous trial of and inadequate response or intolerance to TWO of the following medications: (A) One of the following wakefulness promoting medications: (i) Modafinil or (ii) Nuvigil (armodafinil) AND (B) One of the following stimulants: (i) Methylphenidate (ii) Dextroamphetamine or (iii) Amphetamine/dextroamphetamine salt immediate-release OR (6) Trials of wakefulness promoting agents and stimulant agents are not acceptable due to concomitant clinical situations including but not limited to the following: (1) Cardiovascular disease or (2) Drug interactions. For Renewal of Narcolepsy type I or II, Xyrem (sodium oxybate) use has resulted in a reduction in frequency of cataplexy attacks OR use has resulted in a reduction in excessive daytime sleepiness (EDS) as measured by improvement in Epworth Sleepiness Scale (ESS) measurements or Maintenance of Wakefulness Test (MWT). For continuation, use has resulted in a reduction in frequency of cataplexy attacks compared to baseline OR use has resulted in a reduction in excessive daytime sleepiness (EDS) as measured by improvement in Epworth Sleepiness Scale (ESS) measurements or Maintenance of Wakefulness Test (MWT) compared to baseline
Indications	All Medically-accepted Indications.
Off Label Uses	

Yonsa

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	Individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy.
Indications	All Medically-accepted Indications.
Off Label Uses	

Zarxio

Products Affected

- ZARXIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Febrile neutropenic individuals who are at risk for infection-associated complications or have any of the following: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10to the power of 9/L) neutropenia, Age greater than 65 years, Pneumonia or other clinically documented infection, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, prior episode of FN, or Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than 20% based on chemotherapy in patients who have other patient specific risk factors for FN including any of the following: Individual age greater than 65 years, Poor performance status (ECOG status 3-4), prior chemotherapy or radiation therapy, Bone marrow involvement by tumor producing cytopenias, persistent neutropenia (ANC less than 1500mm3), poor renal function (GFR less than 60mL/min) , liver dysfunction (liver function tests at least 2x upper limit of normal) or recent surgery and/or presence of open wounds.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.

PA Criteria	Criteria Details
Other Criteria	Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. Using for adjunctive tx for FN and has been prophylactic therapy with GCSF agent or has not received prophylactic therapy with a GCSF and who are at high risk for infection-associated complications. Use in acute lymphocytic leukemia (ALL) after completion of the first few days of initial induction chemotherapy or first post-remission course of chemotherapy. Use in individuals with acute myeloid leukemia (AML) shortly after the completion of induction or repeat induction chemotherapy, or after the completion of consolidation chemotherapy for AML. For tx of moderate to severe aplastic anemia. Tx of severe neutropenia in individuals with hairy cell leukemia. For myelodysplastic syndromes (MDS) with severe neutropenia (absolute neutrophil count (ANC) less than or equal to 500 mm3 or experiencing recurrent infection. For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for adjuvant treatment of breast cancer. For chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic individuals with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. For tx of (non-chemotherapy) drug-induced neutropenia. For tx of low neutrophil counts in individuals with glycogen storage disease type 1b. For tx of neutropenia associated with human immunodeficiency virus (HIV) infection and antiretroviral therapy. In individuals receiving radiation therapy in the absence of chemotherapy if prolonged delays secondary to neutropenia are expected. After accidental or intentional total body radiation of myleosuppressive doses (greater than 2 Grays [Gy] (such as Hematopoietic Syndrome of Acute Radiation Syndrome). After hematopoietic progenitor stem cell transplant (HPCT/HSCT) to promote myeloid reconstitution or when engraftment is delayed or has failed. To mobilize progenitor cells into peripheral blood for
	collection by leukapheresis, as an adjunct to peripheral blood/hematopoietic stem cell transplantation (PBSCT/PHSCT). Use as an alternate or adjunct to donor leukocyte infusions (DLI) in individuals with leukemic relapse after an allogeneic hematopoietic stem cell transplant.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	

Zejula

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	In the last 8 weeks, the individual has had a complete or partial response to a platinum-based chemotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

Zelboraf

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	Individuals with wild-type BRAF melanoma.
Required Medical Information	Individual has BRAF mutation and a copy of the BRAF test results must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Zolinza

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Zulresso

Products Affected

- ZULRESSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	Individual is 6 months postpartum or less AND has a diagnosis of moderate to severe postpartum depression consistent with qualifying score using a standardized screening tool for depression (such as, but not limited to, Hamilton Rating Scale for Depression [HAM-D], Patient Health Questionnaire [PHQ-9], Beck Depression Inventory [BDI], Montgomery-Asberg Depression Rating Scale [MADRS], Edinburgh Postnatal Depression Scale [EPDS]).
Indications	All Medically-accepted Indications.
Off Label Uses	

Zydelig

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Zykadia

Products Affected

- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Zytiga

Products Affected

- *abiraterone acetate*
- ZYTIGA ORAL TABLET 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy.
Indications	All Medically-accepted Indications.
Off Label Uses	

Zyvox

Products Affected

- *linezolid oral suspension reconstituted*
- *linezolid oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed vancomycin-resistant enterococcus faecium (VRE) infection. Confirmed methicillin-resistant S. aureus (MRSA) infection AND individual has had a trial and inadequate response or intolerance to or has contraindications to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns, examples of alternative antibiotics may include, but are not limited to: vancomycin, TMP-SMX, clindamycin, doxycycline, tetracycline (Based on 2011 IDSA MRSA guideline recommendations)). Individual started treatment with Zyvox in the hospital and requires continued outpatient therapy. Isolates of MRSA have a vancomycin minimum inhibitory concentration (MIC) of greater than 2.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

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