



An Independent Licensee of the Blue Cross Blue Shield Association

# **Prior Authorization Requirements**

**Effective: 07/01/2023**

# ABEMACICLIB

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## Products Affected

- VERZENIO

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

# ABIRATERONE

## Products Affected

- *abiraterone*

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

# ABIRATERONE SUBMICRONIZED

**Products Affected**

- YONSA

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

# ACALABRUTINIB

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## Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

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

# ADAGRASIB

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## Products Affected

- KRAZATI

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

# ADALIMUMAB

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OPHTHALMOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA, PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL

PA Criteria	Criteria Details
	<p>THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIEN E, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CD, UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. UVEITIS: NO ISOLATED ANTERIOR UVEITIS. RENEWAL: RA, PJA, PSA, AS, PSO, HIDRADENITIS SUPPURATIVA, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# AFATINIB

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## Products Affected

- GILOTRIF

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

# ALECTINIB

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## Products Affected

- ALECENSA

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

# ALPELISIB

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## Products Affected

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

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

# AMBRISENTAN

## Products Affected

- *ambrisentan*

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

# AMIVANTAMAB-VMJW

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## Products Affected

- RYBREVANT

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

# APALUTAMIDE

## Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

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

# APOMORPHINE

## Products Affected

- *apomorphine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	PD: INITIAL: PHYSICIAN HAS OPTIMIZED DRUG THERAPY FOR PD. RENEWAL: IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# ASCIMINIB

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## Products Affected

- SCEMBLIX

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



# ATOGEPANT

## Products Affected

- QULIPTA

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

# AVAPRITINIB

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## Products Affected

- AYVAKIT

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

# AXITINIB

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## Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

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

# AZACITIDINE

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## Products Affected

- ONUREG

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

# AZTREONAM

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## Products Affected

- CAYSTON

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

# BEDAQUILINE

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## Products Affected

- SIRTURO

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

# BELIMUMAB

## Products Affected

- BENLYSTA SUBCUTANEOUS

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

# BELUMOSUDIL

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## Products Affected

- REZUROCK

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



# BELZUTIFAN

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## Products Affected

- WELIREG

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

# BENDAMUSTINE

## Products Affected

- *bendamustine intravenous recon soln*
- BENDAMUSTINE INTRAVENOUS SOLUTION
- BENDEKA

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

# BENRALIZUMAB

## Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	ASTHMA: INITIAL: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ASTHMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
<b>Coverage Duration</b>	INITIAL: 4 MONTHS, RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	ASTHMA: INITIAL: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA. RENEWAL: 1) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL

<b>PA Criteria</b>	<b>Criteria Details</b>
	RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BETAINE

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## Products Affected

- *betaine*

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

# BEVACIZUMAB-ADCD

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## Products Affected

- VEGZELMA

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

# BEVACIZUMAB-AWWB

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## Products Affected

- MVASI

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

# BEVACIZUMAB-BVZR

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## Products Affected

- ZIRABEV

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



# BEXAROTENE

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## Products Affected

- *bexarotene*

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

# BINIMETINIB

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## Products Affected

- MEKTOVI

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

# BORTEZOMIB

## Products Affected

- *bortezomib injection recon soln 1 mg, 2.5 mg*
- BORTEZOMIB INTRAVENOUS RECON SOLN
- VELCADE

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

# BOSENTAN

## Products Affected

- TRACLEER ORAL TABLET
- TRACLEER ORAL TABLET FOR SUSPENSION

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# BOSUTINIB

## Products Affected

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

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

# BRIGATINIB

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## Products Affected

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

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

# C1 ESTERASE INHIBITOR-HAEGARDA

## Products Affected

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

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



# CABOZANTINIB

## Products Affected

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

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

# CABOZANTINIB S-MALATE - CABOMETYX

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## Products Affected

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

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

# CANNABIDIOL

## Products Affected

- EPIDIOLEX

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

# CAPMATINIB

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## Products Affected

- TABRECTA

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

# CARGLUMIC ACID

## Products Affected

- *carglumic acid*

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

# CERITINIB

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## Products Affected

- ZYKADIA

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

# CETUXIMAB

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## Products Affected

- ERBITUX

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

# CLOBAZAM-SYMPAZAN

## Products Affected

- SYMPAZAN

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



# COBIMETINIB

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## Products Affected

- COTELLIC

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

# COLCHICINE

## Products Affected

- *colchicine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PROPHYLAXIS OF GOUT FLARES: 16 YEARS AND OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PROPHYLAXIS OF GOUT FLARES: TRIAL OF OR CONTRAINDICATION TO COLCHICINE CAPSULES (MITIGARE) IF AGE 18 YEARS OR OLDER.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# CRIZOTINIB

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## Products Affected

- XALKORI

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

# CYSTEAMINE HYDROCHLORIDE

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## Products Affected

- CYSTARAN

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

# DABRAFENIB

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## Products Affected

- TAFINLAR ORAL CAPSULE

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

# DABRAFENIB SUSPENSION

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## Products Affected

- TAFINLAR ORAL TABLET FOR SUSPENSION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	UNABLE TO SWALLOW TAFINLAR CAPSULES.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DACOMITINIB

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## Products Affected

- VIZIMPRO

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

# DALFAMPRIDINE

## Products Affected

- *dalfampridine*

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



# DAROLUTAMIDE

## Products Affected

- NUBEQA

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# DASATINIB

## Products Affected

- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

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

# DECITABINE/CEDAZURIDINE

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## Products Affected

- INQOVI

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

# DEFERASIROX

## Products Affected

- *deferasirox*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT): 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) AND 2) LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G DRY WEIGHT OR GREATER. RENEWAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). NTDT: 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR 2) LIC OF 3 MG FE/G DRY WEIGHT OR GREATER.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: CHRONIC IRON OVERLOAD: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL FOR ALL INDICATIONS: FORMULARY VERSION OF DEFERASIROX SPRINKLE: TRIAL OF OR CONTRAINDICATION TO GENERIC DEFERASIROX TABLET OR TABLET FOR ORAL SUSPENSION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DENOSUMAB-XGEVA

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## Products Affected

- XGEVA

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

# DEUTETRABENAZINE

## Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 24 MG, 6 MG

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

# DEXMEDETOMIDINE

## Products Affected

- IGALMI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ACUTE AGITATION: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST.
<b>Coverage Duration</b>	INITIAL: 1 MO. RENEWAL: SEE OTHER CRITERIA.
<b>Other Criteria</b>	ACUTE AGITATION: INITIAL: TRIAL AND FAILURE OF OR CONTRAINDICATION TO TWO ANTIPSYCHOTICS. RENEWAL: 1) MAINTENANCE THERAPY FOR UNDERLYING PSYCHIATRIC DISORDER IS CURRENTLY ADJUSTED/OPTIMIZED TO REDUCE/ELIMINATE THE NEED FOR CONTINUED PRN MEDICATIONS: 3 MONTHS, OR 2) ATTEMPTS TO ADJUST MEDICATIONS HAVE BEEN EXHAUSTED AND PHYSICIAN DETERMINED THAT CHRONIC PRN MEDICATIONS ARE REQUIRED FOR THE CONTINUED SAFETY OF PATIENT OR CAREGIVERS: 6 MONTHS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# DICLOFENAC GEL

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## Products Affected

- *diclofenac sodium topical gel 3 %*

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

# DIMETHYL FUMARATE

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## Products Affected

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

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

# DIROXIMEL FUMARATE

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## Products Affected

- VUMERITY

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

# DOSTARLIMAB-GXLY

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## Products Affected

- JEMPERLI

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

# DRONABINOL

## Products Affected

- *dronabinol*

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

# DROXIDOPA

## Products Affected

- *droxidopa*

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

# DUPILUMAB

## Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: EOSINOPHILIC ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS. EOSINOPHILIC ESOPHAGITIS (EOE): DIAGNOSIS CONFIRMED BY ESOPHAGOGASTRODUODENOSCOPY (EGD) WITH BIOPSY.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: AD, PN: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOE: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, ALLERGIST, OR IMMUNOLOGIST.
<b>Coverage Duration</b>	INITIAL: AD, CRSWNP, EOE, PN: 6 MOS, ASTHMA: 4 MOS. RENEWAL: ALL INDICATIONS: 12 MOS.
<b>Other Criteria</b>	INITIAL: AD: 1) AD COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR AD AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS, 2) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, 3) TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID, CALCINEURIN INHIBITOR, PDE4 INHIBITOR, OR JAK INHIBITOR), AND 4) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGIC/JAK INHIBITOR FOR AD. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS, OR ONE SERIOUS EXACERBATION REQUIRING

PA Criteria	Criteria Details
	<p>HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NO CONCURRENT USE WITH XOLAIR OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. CRSWNP: 1) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY OR SINUS CT SCAN, 2) INADEQUATELY CONTROLLED DISEASE AS DETERMINED BY USE OF SYSTEMIC STEROIDS IN THE PAST 2 YEARS OR ENDOSCOPIC SINUS SURGERY, AND 3) A 90 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID. PN: 1) CHRONIC PRURITIS (ITCH MORE THAN 6 WEEKS), MULTIPLE PRURIGINOUS LESIONS, AND HISTORY OR SIGN OF A PROLONGED SCRATCHING BEHAVIOR, 2) TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID OR CALCIPOTRIOL). RENEWAL: AD: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGIC/JAK INHIBITOR FOR AD. CRSWNP, EOE: IMPROVEMENT WHILE ON THERAPY. ASTHMA: 1) NO CONCURRENT USE WITH XOLAIR, OR OTHER ANTI-IL5 BIOLOGICS FOR ASTHMA, 2) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS. PN: IMPROVEMENT OR REDUCTION OF PRURITIS OR PRURIGINOUS LESIONS.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# DUVELISIB

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## Products Affected

- COPIKTRA

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

# ELACESTRANT

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## Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

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

# ELEXACAFITOR-TEZACAFITOR-IVACAFITOR

## Products Affected

- TRIKAFTA ORAL TABLETS, SEQUENTIAL

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

# ELTROMBOPAG

## Products Affected

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

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

# ENASIDENIB

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## Products Affected

- IDHIFA

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

# ENCORAFENIB

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## Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

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

# ENTRECTINIB

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## Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

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

# ENZALUTAMIDE

## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: CASTRATION-RESISTANT PROSTATE CANCER (CRPC) THAT IS NOT METASTATIC: PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). CRPC (INCLUDES NON-METASTATIC AND METASTATIC) OR METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: DIAGNOSIS OF CRPC (INCLUDES NON-METASTATIC AND METASTATIC) OR MCSPC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# EPCORITAMAB-BYSP

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## Products Affected

- EPKINLY

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

# EPOETIN ALFA-EPBX

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: CHRONIC KIDNEY DISEASE (CKD), ANEMIA RELATED TO ZIDOVUDINE, OR CANCER CHEMOTHERAPY: HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. ELECTIVE, NON-CARDIAC, NON-VASCULAR SURGERY: HEMOGLOBIN LEVEL LESS THAN 13G/DL. RENEWAL: CKD: 1) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR 2) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA RELATED TO ZIDOVUDINE: HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. CANCER CHEMOTHERAPY: 1) HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL, OR 2) THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: INITIAL/RENEWAL: 12 MONTHS. SURGERY: 1 MONTH.
<b>Other Criteria</b>	RENEWAL: CKD: NOT RECEIVING DIALYSIS TREATMENT. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ERDAFITINIB

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## Products Affected

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

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

# ERLOTINIB

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## Products Affected

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

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

# ESKETAMINE

## Products Affected

- SPRAVATO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: TREATMENT-RESISTANT DEPRESSION (TRD), MAJOR DEPRESSIVE DISORDER (MDD): PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST.
<b>Coverage Duration</b>	INITIAL: TRD: 3 MONTHS. MDD: 4 WEEKS. RENEWAL: TRD, MDD: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: TRD: 1) NON-PSYCHOTIC, UNIPOLAR DEPRESSION, 2) NO ACTIVE SUBSTANCE ABUSE, AND 3) ADEQUATE TRIAL (AT LEAST 4 WEEKS) OF AT LEAST TWO ANTIDEPRESSANT AGENTS FROM DIFFERENT CLASSES THAT ARE INDICATED FOR DEPRESSION. MDD: 1) NON-PSYCHOTIC, UNIPOLAR DEPRESSION, AND 2) NO ACTIVE SUBSTANCE ABUSE. RENEWAL: TRD, MDD: DEMONSTRATED CLINICAL BENEFIT (IMPROVEMENT IN DEPRESSION) COMPARED TO BASELINE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ETANERCEPT

## Products Affected

- ENBREL
- ENBREL SURECLICK
- ENBREL MINI

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# EVEROLIMUS

## Products Affected

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

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



# FEDRATINIB

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## Products Affected

- INREBIC

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

# FENFLURAMINE

## Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: DRAVET SYNDROME, LENNOX-GASTAUT SYNDROME (LGS): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	DRAVET SYNDROME: INITIAL/RENEWAL: 12 MONTHS. LGS: 12 MONTHS.
Other Criteria	INITIAL: LGS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM. RENEWAL: DRAVET SYNDROME: PATIENT HAS SHOWN CONTINUED CLINICAL BENEFIT (E.G. REDUCTION OF SEIZURES, REDUCED LENGTH OF SEIZURES, SEIZURE CONTROL MAINTAINED).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# FENTANYL CITRATE

## Products Affected

- *fentanyl citrate buccal lozenge on a handle*

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

# FILGRASTIM-AAFI

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## Products Affected

- NIVESTYM

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

# FINERENONE

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## Products Affected

- KERENDIA

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

# FINGOLIMOD

## Products Affected

- *fingolimod*
- GILENYA ORAL CAPSULE 0.25 MG

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

# FREMANEZUMAB-VFRM

## Products Affected

- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

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

# FUTIBATINIB

## Products Affected

- LYTGOBI

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



# GALCANEZUMAB-GNLM

## Products Affected

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

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

# GANAXOLONE

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## Products Affected

- ZTALMY

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

# GEFITINIB

## Products Affected

- *gefitinib*
- IRESSA

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

# GILTERITINIB

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## Products Affected

- XOSPATA

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

# GLASDEGIB

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## Products Affected

- DAURISMO ORAL TABLET 100 MG,  
25 MG

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

# GLATIRAMER

## Products Affected

- COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML
- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*
- *glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml*

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

# GOSERELIN

## Products Affected

- ZOLADEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
<b>Coverage Duration</b>	STAGE B2-C PROSTATIC CARCINOMA: 4 MOS. ENDOMETRIOSIS: 6 MOS PER LIFETIME. ALL OTHERS: 12 MONTHS.
<b>Other Criteria</b>	ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 6 MONTHS OF TREATMENT PER LIFETIME. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# GUSELKUMAB

## Products Affected

- TREMFYA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). PSO: TRIAL OF OR CONTRAINDICATION ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# HIGH CONCENTRATION ORAL OPIOID SOLUTIONS

## Products Affected

- *morphine concentrate oral solution*

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

# IBRUTINIB

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## Products Affected

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

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

# IBUPROFEN-FAMOTIDINE

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## Products Affected

- *ibuprofen-famotidine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF ONE OF THE FOLLOWING GENERIC, FEDERAL LEGEND HISTAMINE H2-RECEPTOR ANTAGONISTS: FAMOTIDINE, CIMETIDINE, OR NIZATIDINE, AND TRIAL OF GENERIC, FEDERAL LEGEND IBUPROFEN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# ICATIBANT

## Products Affected

- *icatibant*
- *sajazir*

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

# IDELALISIB

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## Products Affected

- ZYDELIG

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

# IMATINIB

## Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

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

# INFIGRATINIB

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## Products Affected

- TRUSELTIQ

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

# INTERFERON ALFA-2B

## Products Affected

- INTRON A INJECTION RECON SOLN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HEPATITIS C: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).
<b>Coverage Duration</b>	6 MONTHS.
<b>Other Criteria</b>	HEPATITIS C: 1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) TRIAL OF OR CONTRAINDICATION TO PEGINTERFERON ALFA-2A OR PEGINTERFERON ALFA-2B, 3) USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED AND 4) LIMITED TO TOTAL OF 24 MONTHS OF TREATMENT. FOLLICULAR LYMPHOMA: LIMITED TO TOTAL OF 18 MONTHS OF TREATMENT. ALL OTHER INDICATIONS: LIMITED TO TOTAL OF 1 YEAR OF TREATMENT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# INTERFERON FOR MS-AVONEX

## Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

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

# INTERFERON FOR MS-BETASERON

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## Products Affected

- BETASERON SUBCUTANEOUS KIT

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

# INTERFERON GAMMA-1B

## Products Affected

- ACTIMMUNE

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

# IPILIMUMAB

## Products Affected

- YERVOY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: UNRESECT/MET MEL: 4MO, RCC/CRC/HCC: 3MO, ALL OTHERS: 12MO. INITIAL/RENEWAL: CUTAN MEL: 6MO
Other Criteria	RENEWAL: ADJUVANT CUTANEOUS MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# IVACAFTOR

## Products Affected

- KALYDECO

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

# IVOSIDENIB

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## Products Affected

- TIBSOVO

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

# IXAZOMIB

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## Products Affected

- NINLARO

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

# LANREOTIDE

## Products Affected

- *lanreotide* MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3 ML
- SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 120

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACROMEGALY: INITIAL: THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	ACROMEGALY: INITIAL: 3 MOS, RENEWAL: 12 MOS.GEP-NETS, CARCINOID SYNDROME: 12 MOS.
Other Criteria	ACROMEGALY: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE GENERIC OCTREOTIDE INJECTION. RENEWAL: 1) REDUCTION, NORMALIZATION, OR MAINTENANCE OF IGF-1 LEVELS BASED ON AGE AND GENDER, AND 2) IMPROVEMENT OR SUSTAINED REMISSION OF CLINICAL SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# LAPATINIB

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## Products Affected

- *lapatinib*

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

# LAROTRECTINIB

## Products Affected

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

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

# LEDIPASVIR-SOFOSBUVIR

## Products Affected

- HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG
- HARVONI ORAL TABLET

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

# LENALIDOMIDE

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## Products Affected

- *lenalidomide*

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

# LENVATINIB

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## Products Affected

- LENVIMA

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

# LETERMOVIR

## Products Affected

- PREVYMIS INTRAVENOUS SOLUTION 240 MG/12 ML, 480 MG/24 ML
- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 MONTHS
Other Criteria	HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT): THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 28 POST TRANSPLANTATION AND PATIENT IS NOT RECEIVING THE MEDICATION BEYOND 100 DAYS POST TRANSPLANTATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# LEUPROLIDE

## Products Affected

- *leuprolide subcutaneous kit*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: CENTRAL PRECOCIOUS PUBERTY (CPP): FEMALES: ELEVATED LEVELS OF FOLLICLE-STIMULATING HORMONE (FSH) GREATER THAN 4.0 MIU/ML AND LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVELS OF FSH GREATER THAN 5.0 MIU/ML AND LH LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: CPP: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
<b>Coverage Duration</b>	PROSTATE CANCER: 12 MONTHS. CPP: INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	CPP: INITIAL: FEMALES: 1) YOUNGER THAN 8 YEARS OF AGE AT ONSET OF CPP, AND 2) DOCUMENTATION OF PUBERTAL STAGING USING THE TANNER SCALE FOR BREAST DEVELOPMENT (STAGE 2 OR ABOVE) AND PUBIC HAIR GROWTH (STAGE 2 OR ABOVE). MALES: 1) YOUNGER THAN 9 YEARS OF AGE AT ONSET OF CPP, AND 2) DOCUMENTATION OF PUBERTAL STAGING USING THE TANNER SCALE FOR GENITAL DEVELOPMENT (STAGE 2 OR ABOVE) AND PUBIC HAIR GROWTH (STAGE 2 OR ABOVE). RENEWAL: 1) TANNER SCALE STAGING AT INITIAL DIAGNOSIS OF CPP HAS STABILIZED OR REGRESSED DURING THREE SEPARATE MEDICAL VISITS IN THE PREVIOUS YEAR, AND 2) PATIENT HAS NOT REACHED ACTUAL AGE WHICH CORRESPONDS TO CURRENT PUBERTAL AGE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No



# LEUPROLIDE DEPOT

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## Products Affected

- *leuprolide (3 month)*

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

# LEUPROLIDE-ELIGARD

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## Products Affected

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

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

# LEUPROLIDE-LUPRON DEPOT

## Products Affected

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

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# LIDOCAINE

## Products Affected

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

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

# LIDOCAINE PRILOCAINE

## Products Affected

- *lidocaine-prilocaine topical cream*

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

# LONCASTUXIMAB TESIRINE-LPYL

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## Products Affected

- ZYNLONTA

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

# LORLATINIB

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## Products Affected

- LORBRENA ORAL TABLET 100 MG,  
25 MG

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



# LUMACAFITOR-IVACAFITOR

## Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

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

# MARGETUXIMAB-CMKB

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## Products Affected

- MARGENZA

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

# MEPOLIZUMAB

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE. NASAL POLYPS: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST.
<b>Coverage Duration</b>	INITIAL: ASTHMA: 4 MO. NASAL POLYPS: 6 MO. OTHERS: 12 MO. RENEWAL: NASAL POLYPS, ASTHMA: 12 MO.
<b>Other Criteria</b>	INITIAL: ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA. NASAL POLYPS: PREVIOUS 90 DAY

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID. RENEWAL: ASTHMA: 1) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. NASAL POLYPS: CLINICAL BENEFIT COMPARED TO BASELINE.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# MIDOSTAURIN

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## Products Affected

- RYDAPT

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

# MIFEPRISTONE

## Products Affected

- KORLYM

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	CUSHINGS SYNDROME (CS): INITIAL: DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: 1) 24-HR URINE FREE CORTISOL (2 OR MORE TESTS TO CONFIRM), 2) OVERNIGHT 1MG DEXAMETHASONE TEST, OR 3) LATE NIGHT SALIVARY CORTISOL (2 OR MORE TESTS TO CONFIRM).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CS: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
<b>Coverage Duration</b>	INITIAL AND RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	CS: INITIAL: HYPERCORTISOLISM IS NOT A RESULT OF CHRONIC GLUCOCORTICIDS. RENEWAL: 1) CONTINUES TO HAVE IMPROVEMENT OF GLUCOSE TOLERANCE OR STABLE GLUCOSE TOLERANCE (E.G., REDUCED A1C, IMPROVED FASTING GLUCOSE, ETC.), 2) CONTINUES TO HAVE TOLERABILITY TO KORLYM, AND 3) CONTINUES TO NOT BE A CANDIDATE FOR SURGICAL TREATMENT OR HAS FAILED SURGERY.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# MIGLUSTAT

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## Products Affected

- *miglustat*

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

# MOBOCERTINIB

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## Products Affected

- EXKIVITY

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



# MOSUNETUZUMAB-AXGB

## Products Affected

- LUNSUMIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA: INITIAL: 6 MONTHS. RENEWAL: 7 MONTHS.
Other Criteria	RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA: RENEWAL: 1) HAS ACHIEVED A PARTIAL RESPONSE TO TREATMENT, AND 2) HAS NOT PREVIOUSLY RECEIVED MORE THAN 17 CYCLES OF TREATMENT. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# NAFARELIN

## Products Affected

- SYNAREL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS. CENTRAL PRECOCIOUS PUBERTY (CPP): FEMALES: ELEVATED LEVELS OF FOLLICLE-STIMULATING HORMONE (FSH) GREATER THAN 4.0 MIU/ML AND LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVELS OF FSH GREATER THAN 5.0 MIU/ML AND LH LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST. CPP: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
<b>Coverage Duration</b>	ENDOMETRIOSIS: 6 MONTHS. CPP: INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 6 MONTHS OF TREATMENT PER LIFETIME. CPP: FEMALES: 1) YOUNGER THAN 8 YEARS OF AGE AT ONSET OF CPP, AND 2) DOCUMENTATION OF PUBERTAL STAGING USING THE TANNER SCALE FOR BREAST DEVELOPMENT (STAGE 2 OR ABOVE) AND PUBIC HAIR GROWTH (STAGE 2 OR ABOVE). MALES: 1) YOUNGER THAN 9 YEARS OF AGE AT ONSET OF CPP, AND 2) DOCUMENTATION OF PUBERTAL STAGING USING THE TANNER SCALE FOR GENITAL DEVELOPMENT (STAGE 2 OR ABOVE) AND PUBIC HAIR GROWTH (STAGE 2 OR ABOVE). RENEWAL: CPP: 1) TANNER SCALE STAGING AT INITIAL

<b>PA Criteria</b>	<b>Criteria Details</b>
	DIAGNOSIS OF CPP HAS STABILIZED OR REGRESSED DURING THREE SEPARATE MEDICAL VISITS IN THE PREVIOUS YEAR, AND 2) HAS NOT REACHED ACTUAL AGE WHICH CORRESPONDS TO CURRENT PUBERTAL AGE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NARCOLEPSY AGENTS

## Products Affected

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

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

# NAXITAMAB-GQGK

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## Products Affected

- DANYELZA

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

# NERATINIB MALEATE

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## Products Affected

- NERLYNX

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

# NILOTINIB

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## Products Affected

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

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

# NINTEDANIB

## Products Affected

- OFEV

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) BASELINE FORCED VITAL CAPACITY (FVC) AT LEAST 50% OF PREDICTED VALUE. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) BASELINE FVC AT LEAST 40% OF PREDICTED VALUE. CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE (PF-ILD): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) BASELINE FVC AT LEAST 45% OF PREDICTED VALUE.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	<p>INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. SSC-ILD, PF-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.</p>
<b>Coverage Duration</b>	<p>INITIAL: SSC-ILD: 6 MOS. IPF, PF-ILD: 12 MOS. RENEWAL (ALL INDICATIONS): 12 MOS.</p>
<b>Other Criteria</b>	<p>INITIAL: IPF: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS), AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ESBRIET (PIRFENIDONE). SSC-ILD: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., HEART FAILURE/FLUID OVERLOAD, DRUG-INDUCED LUNG TOXICITY, RECURRENT ASPIRATION), AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ACTEMRA SUBQ. PF-ILD: LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE</p>



<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>WORSENERD/PROGRESSEB DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILB (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE). RENEWAL: IPF, SSC-ILB, PF-ILB: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NIRAPARIB

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## Products Affected

- ZEJULA

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

# NITISINONE

## Products Affected

- *nitisinone*
- ORFADIN ORAL SUSPENSION

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

# NIVOLUMAB

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## Products Affected

- OPDIVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT USE WITH TARGETED THERAPY (I.E., BRAF INHIBITORS, MEK INHIBITORS, AND NTRK INHIBITORS).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NIVOLUMAB-RELATLIMAB-RMBW

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## Products Affected

- OPDUALAG

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

# OLANZAPINE/SAMIDORPHAN

## Products Affected

- LYBALVI

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

# OLAPARIB

## Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER: 1) MEDICATION WILL BE USED AS MONOTHERAPY, AND 2) PATIENT HAS COMPLETED TWO OR MORE LINES OF PLATINUM-BASED CHEMOTHERAPY. METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# OLUTASIDENIB

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## Products Affected

- REZLIDHIA

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



# OMACETAXINE

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## Products Affected

- SYNRIPO

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

# OMALIZUMAB

## Products Affected

- XOLAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: ASTHMA: POSITIVE SKIN PRICK OR BLOOD TEST (E.G., ELISA, FEIA) TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL AND RENEWAL: CHRONIC IDIOPATHIC URTICARIA (CIU): PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE, DERMATOLOGY OR IMMUNOLOGY. INITIAL: NASAL POLYPS: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
<b>Coverage Duration</b>	INITIAL: ASTHMA: 12 MO. CIU, NASAL POLYPS: 6 MO. RENEWAL: ASTHMA, NASAL POLYPS: 12 MO. CIU: 6 MO.
<b>Other Criteria</b>	INITIAL: CIU: TRIAL OF OR CONTRAINDICATION TO A MAXIMALLY TOLERATED DOSE OF AN H1 ANTI-HISTAMINE AND STILL EXPERIENCES HIVES ON MOST DAYS OF THE WEEK. NASAL POLYPS: 1) PREVIOUS 90 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE PREFERRED AGENT: NUCALA, DUPIXENT. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, 3) NOT CONCURRENTLY RECEIVING DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA.</p> <p>RENEWAL: CIU: DIAGNOSIS OF CIU. NASAL POLYPS: CLINICAL BENEFIT COMPARED TO BASELINE. ASTHMA: 1) NOT CONCURRENTLY RECEIVING DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# OSIMERTINIB

## Products Affected

- TAGRISSO

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

# PACRITINIB

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## Products Affected

- VONJO

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

# PALBOCICLIB

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## Products Affected

- IBRANCE

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

# PANOBINOSTAT

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## Products Affected

- FARYDAK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	MULTIPLE MYELOMA: RENEWAL: TOLERATED THE FIRST 8 CYCLES OF THERAPY WITHOUT UNRESOLVED SEVERE OR MEDICALLY SIGNIFICANT TOXICITY.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PARATHYROID HORMONE

## Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HYPOCALCEMIA SECONDARY TO HYPOPARATHYROIDISM: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	HYPOCALCEMIA SECONDARY TO HYPOPARATHYROIDISM: 1) TRIAL OF OR CONTRAINDICATION TO CALCITRIOL, 2) HYPOPARATHYROIDISM IS NOT DUE TO A CALCIUM SENSING RECEPTOR (CSR) MUTATION, AND 3) HYPOPARATHYROIDISM IS NOT CONSIDERED ACUTE POST-SURGICAL HYPOPARATHYROIDISM.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# PASIREOTIDE DIASPARTATE

## Products Affected

- SIGNIFOR

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

# PAZOPANIB

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## Products Affected

- VOTRIENT

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

# PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS. THIS CRITERIA DOES NOT APPLY TO SILDENAFIL FOR AGES 1 TO 17 YEARS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST. THIS CRITERIA DOES NOT APPLY TO SILDENAFIL FOR AGES 1 TO 17 YEARS.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	PAH: INITIAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE STIMULATORS, AND 2) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) 3 WOOD UNITS OR GREATER. RENEWAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE STIMULATORS, AND 2) IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS. ALL OF THE PRECEDING CRITERIA DOES NOT APPLY TO SILDENAFIL FOR AGES 1 TO 17 YEARS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PEGFILGRASTIM - APGF

## Products Affected

- NYVEPRIA

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

# PEGVISOMANT

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## Products Affected

- SOMAVERT

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

# PEMBROLIZUMAB

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## Products Affected

- KEYTRUDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT USE WITH TARGETED THERAPY (I.E., BRAF INHIBITORS, MEK INHIBITORS, AND NTRK INHIBITORS).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# PEMIGATINIB

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## Products Affected

- PEMAZYRE

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



# PENICILLAMINE

## Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: WILSONS DISEASE: CONFIRMED BY ONE OF THE FOLLOWING: 1) PLASMA COPPER-PROTEIN CERULOPLASMIN IS LESS THAN 20MG/DL, 2) LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS, OR 3) CONFIRMATION BY GENETIC TESTING FOR ATP7B MUTATIONS. CYSTINURIA: PATIENT HAS NEPHROLITHIASIS AND ONE OR MORE OF THE FOLLOWING: 1) STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, 2) IDENTIFICATION OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, OR 3) POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST. CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 12 MONTHS, RENEWAL: LIFETIME.
<b>Other Criteria</b>	INITIAL: WILSONS DISEASE: 1) KNOWN FAMILY HISTORY OF WILSONS DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSONS DISEASE, AND 2) REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRE A TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN). CYSTINURIA: REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRES A TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN) AND A FORMULARY VERSION OF TIOPRONIN (THIOLA)/THIOLA EC. RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, 2) TRIAL OF OR

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

# PEXIDARTINIB

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## Products Affected

- TURALIO

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

# PIMAVANSERIN

## Products Affected

- NUPLAZID

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

# PIRFENIDONE

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	IDIOPATHIC PULMONARY FIBROSIS (IPF): INITIAL: 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) PREDICTED FORCED VITAL CAPACITY (FVC) OF AT LEAST 50% AT BASELINE.
<b>Age Restrictions</b>	IPF: INITIAL: 18 YEARS OR OLDER.
<b>Prescriber Restrictions</b>	IPF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	IPF: INITIAL: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, OR CANCER). RENEWAL: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PIRTOBRUTINIB

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## Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

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

# POMALIDOMIDE

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## Products Affected

- POMALYST

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

# PONATINIB

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## Products Affected

- ICLUSIG

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



# POSACONAZOLE

## Products Affected

- *posaconazole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	OROPHARYNGEAL CANDIDIASIS (OPC): 3 MONTHS. PROPHYLAXIS: 6 MONTHS. TREATMENT: 12 WEEKS.
Other Criteria	POSACONAZOLE SUSPENSION ONLY: 1) OPC: TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE OR ITRACONAZOLE. 2) PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTION: INABILITY TO SWALLOW TABLETS. POSACONAZOLE TABLETS ONLY: TREATMENT OF INVASIVE ASPERGILLOSIS: NO EXTRA CRITERIA REQUIRED. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# POSACONAZOLE-POWDERMIX

## Products Affected

- NOXAFIL ORAL SUSP,DELAYED  
RELEASE FOR RECON

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

# PRALSETINIB

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## Products Affected

- GAVRETO

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

# PYRIMETHAMINE

## Products Affected

- *pyrimethamine*

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

# QUININE

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## Products Affected

- *quinine sulfate*

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

# RAMUCIRUMAB

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## Products Affected

- CYRAMZA

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

# REGORAFENIB

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## Products Affected

- STIVARGA

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

# RELUGOLIX

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## Products Affected

- ORGOVYX

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



# RETIFANLIMAB-DLWR

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## Products Affected

- ZYNYZ

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

# RIBOCICLIB

## Products Affected

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

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

# RIFAXIMIN

## Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

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

# RIMEGEPANT

## Products Affected

- NURTEC ODT

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

# RIPRETINIB

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## Products Affected

- QINLOCK

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

# RISANKIZUMAB-RZAA

## Products Affected

- SKYRIZI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS (PSO): PLAQUE PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). CD: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RITUXIMAB AND HYALURONIDASE HUMAN-SQ

## Products Affected

- RITUXAN HYCELA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# RITUXIMAB-ABBS

## Products Affected

- TRUXIMA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NHL, CLL: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
<b>Coverage Duration</b>	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, GPA, MPA: 12 MO. CLL: 6 MO.
<b>Other Criteria</b>	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# RITUXIMAB-ARRX

## Products Affected

- RIABNI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NHL, CLL: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
<b>Coverage Duration</b>	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, WG, MPA: 12 MO. CLL: 6 MO.
<b>Other Criteria</b>	RA: INITIAL: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RITUXIMAB-PVVR

## Products Affected

- RUXIENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NHL, CLL: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	NHL, GPA, MPA: 12 MONTHS. CLL: 6 MONTHS. RA: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO PREFERRED AGENTS: HUMIRA, ENBREL, RINVOQ, XELJANZ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# ROPEGINTERFERON ALFA-2B-NJFT

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## Products Affected

- BESREMI

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

# RUCAPARIB

## Products Affected

- RUBRACA

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

# RUXOLITINIB

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## Products Affected

- JAKAFI

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

# SAPROPTERIN

## Products Affected

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

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

# SECUKINUMAB

## Products Affected

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

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# SELINEXOR

## Products Affected

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

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

# SELPERCATINIB

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## Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG

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

# SELUMETINIB

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## Products Affected

- KOSELUGO ORAL CAPSULE 10 MG,  
25 MG

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

# SIROLIMUS PROTEIN-BOUND

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## Products Affected

- FYARRO

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

# SODIUM OXYBATE

## Products Affected

- *sodium oxybate*
- XYREM

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

# SOFOSBUVIR/VELPATASVIR

## Products Affected

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

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

# SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

## Products Affected

- VOSEVI

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

# SOMATROPIN - NORDITROPIN

## Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.
<b>Required Medical Information</b>	INITIAL: PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL/RENEWAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. RENEWAL: PEDIATRIC GHD: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND OR PATIENT HAS NOT COMPLETED PREPUBERTAL GROWTH. ISS, SGA, TS, NOONAN SYNDROME: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. PWS: IMPROVEMENT IN BODY COMPOSITION.
<b>Indications</b>	All FDA-approved Indications.



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SOMATROPIN - SEROSTIM

## Products Affected

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

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

# SONIDEGIB

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## Products Affected

- ODOMZO

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

# SORAFENIB

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## Products Affected

- *sorafenib*

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

# SOTORASIB

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## Products Affected

- LUMAKRAS ORAL TABLET 120 MG,  
320 MG

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

# STIRIPENTOL

## Products Affected

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

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

# SUNITINIB

## Products Affected

- *sunitinib malate*

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

# TALAZOPARIB

## Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS BEEN TREATED WITH CHEMOTHERAPY IN THE NEOADJUVANT, ADJUVANT, OR METASTATIC SETTING. PATIENTS WITH HORMONE RECEPTOR (HR)-POSITIVE BREAST CANCER MUST HAVE ADDITIONAL PRIOR TREATMENT WITH ENDOCRINE THERAPY OR BE CONSIDERED INAPPROPRIATE FOR ENDOCRINE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# TALIMOGENE

## Products Affected

- IMLYGIC INJECTION SUSPENSION  
10EXP6 (1 MILLION) PFU/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNRESECTABLE MELANOMA: 1) IMLYGIC TO BE INJECTED INTO CUTANEOUS, SUBCUTANEOUS, AND/OR NODAL LESIONS THAT ARE VISIBLE, PALPABLE, OR DETECTABLE BY ULTRASOUND GUIDANCE, 2) NOT CURRENTLY RECEIVING IMMUNOSUPPRESSIVE THERAPY, 3) NO HISTORY OF PRIMARY OR ACQUIRED IMMUNODEFICIENT STATES, LEUKEMIA, LYMPHOMA, OR AIDS, AND 4) NO CONCURRENT USE WITH PEMBROLIZUMAB, NIVOLUMAB, IPILIMUMAB, DABRAFENIB, TRAMETINIB, VEMURAFENIB, INTERLEUKIN-2, INTERFERON, DACARBAZINE, TEMOZOLOMIDE, PACLITAXEL, CARBOPLATIN, IMATINIB, MELPHALAN, IMIQUIMOD, OR RADIATION THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# TASIMELTEON

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## Products Affected

- *tasimelteon*

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

# TAZEMETOSTAT

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## Products Affected

- TAZVERIK

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

# TEBENTAFUSP-TEBN

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## Products Affected

- KIMMTRAK

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

# TECLISTAMAB-CQYV

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## Products Affected

- TECVAYLI

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

# TEDUGLUTIDE

## Products Affected

- GATTEX 30-VIAL

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

# TELOTRISTAT

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## Products Affected

- XERMELO

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

# TEPOTINIB

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## Products Affected

- TEPMETKO

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



# TERIFLUNOMIDE

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## Products Affected

- *teriflunomide*

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

# TESTOSTERONE

## Products Affected

- *testosterone cypionate*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet 1 % (50 mg/5 gram)*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: MALE HYPOGONADISM: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	MALE HYPOGONADISM: INITIAL/RENEWAL:12 MO. ALL OTHER INDICATIONS: LIFETIME OF MEMBERSHIP IN PLAN.
<b>Other Criteria</b>	RENEWAL: MALE HYPOGONADISM: IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TETRABENAZINE

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## Products Affected

- *tetrabenazine*

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

# TEZACAFTOR/IVACAFTOR

## Products Affected

- SYMDEKO

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

# THALIDOMIDE

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## Products Affected

- THALOMID

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

# TISOTUMAB VEDOTIN-TFTV

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## Products Affected

- TIVDAK

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

# TIVOZANIB

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## Products Affected

- FOTIVDA

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

# TOFACITINIB

## Products Affected

- XELJANZ
- XELJANZ XR

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



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# TOPICAL TRETINOIN

## Products Affected

- *tretinoin topical cream*
- *tretinoin topical gel 0.01 %, 0.025 %*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	COSMETIC INDICATIONS SUCH AS WRINKLES, PHOTOAGING, MELASMA.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	ACNE VULGARIS: BRAND TOPICAL TRETINOIN REQUIRES TRIAL OF OR CONTRAINDICATION TO A GENERIC TOPICAL TRETINOIN PRODUCT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TRAMETINIB

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## Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

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

# TRAMETINIB SOLUTION

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## Products Affected

- MEKINIST ORAL RECON SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	UNABLE TO SWALLOW MEKINIST TABLETS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TRASTUZUMAB HYALURONIDASE

## Products Affected

- HERCEPTIN HYLECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADJUVANT BREAST CANCER, METASTATIC BREAST CANCER: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: HERZUMA, OGIVRI, ONTRUZANT, TRAZIMERA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# TRASTUZUMAB-DKST

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## Products Affected

- OGIVRI

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

# TRASTUZUMAB-DTTB

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## Products Affected

- ONTRUZANT

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

# TRASTUZUMAB-PKRB

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## Products Affected

- HERZUMA

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



# TRASTUZUMAB-QYYP

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## Products Affected

- TRAZIMERA

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

# TREMELIMUMAB-ACTL

## Products Affected

- IMJUDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	UHCC: 30 DAYS. METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC): 5 MONTHS.
Other Criteria	UNRESECTABLE HEPATOCELLULAR CARCINOMA (UHCC): HAS NOT RECEIVED PRIOR TREATMENT WITH IMJUDO.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# TRIENTINE

## Products Affected

- *trientine*

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

# TRIFLURIDINE/TIPIRACIL

## Products Affected

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

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

# TRIPTORELIN-TRELSTAR

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## Products Affected

- TRELSTAR INTRAMUSCULAR  
SUSPENSION FOR RECONSTITUTION

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

# TUCATINIB

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## Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

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

# UBROGEPANT

## Products Affected

- UBRELVY

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

# UPADACITINIB

## Products Affected

- RINVOQ

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: RA, AS, NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. AD: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST. UC: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. ATOPIC DERMATITIS: 1) ATOPIC DERMATITIS COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS, 2) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, 3) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING: TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, OR TOPICAL JAK INHIBITOR, AND 4) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGIC/JAK INHIBITOR FOR THE TREATMENT OF ATOPIC DERMATITIS. UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH



PA Criteria	Criteria Details
	<p>AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). RENEWAL: RA, PSA, AS, NR-AXSPA: CONTINUES TO BENEFIT FROM THE MEDICATION. ATOPIC DERMATITIS: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGIC/JAK INHIBITOR FOR THE TREATMENT OF ATOPIC DERMATITIS.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# USTEKINUMAB

## Products Affected

- STELARA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CD, UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# USTEKINUMAB IV

## Products Affected

- STELARA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	2 MONTHS
<b>Other Criteria</b>	CD, UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VANDETANIB

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## Products Affected

- CAPRELSA ORAL TABLET 100 MG,  
300 MG

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

# VEMURAFENIB

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## Products Affected

- ZELBORAF

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

# VENETOCLAX

## Products Affected

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

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

# VIGABATRIN

## Products Affected

- *vigabatrin*
- *vigadrone*

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

# VISMODEGIB

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## Products Affected

- ERIVEDGE

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



# VORICONAZOLE SUSPENSION

## Products Affected

- *voriconazole oral suspension for reconstitution*

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

# ZANUBRUTINIB

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## Products Affected

- BRUKINSA

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

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