# PA Criteria

| | |
|---|---|
| ***Prior Authorization Group*** | ABIRATERONE |
| ***Drug Names*** | ABIRATERONE ACETATE, ZYTIGA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Node-positive (N1), non-metastatic (M0) prostate cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ACITRETIN |
| ***Drug Names*** | ACITRETIN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ACTIMMUNE |
| ***Drug Names*** | ACTIMMUNE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Mycosis fungoides, Sezary syndrome, atopic dermatitis. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ADEMPAS |
| ***Drug Names*** | ADEMPAS |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (PAH) (WHO Group 1): PAH was confirmed by right heart catheterization. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. For new starts only (excluding recurrent/persistent CTEPH after PEA): 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | AFINITOR |
| ***Drug Names*** | AFINITOR, AFINITOR DISPERZ |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Classical Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma subtypes: perivascular epithelioid cell tumors (PEComa), lymphangioleiomyomatosis, gastrointestinal stromal tumors, neuroendocrine tumor of the thymus, thyroid carcinoma (papillary, Hurthle cell, and follicular), endometrial carcinoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For breast cancer: 1) The disease is recurrent or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, and 2) The requested medication is prescribed in combination with exemestane, fulvestrant, or tamoxifen, and 3) The patient has received endocrine therapy within 1 year. For renal cell carcinoma: 1) The disease is relapsed, metastatic or unresectable, and 2) For disease that is of predominantly clear cell histology, disease has progressed on prior therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | AIMOVIG |
| ***Drug Names*** | AIMOVIG |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 2) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 3) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial 3 months, Reauthorization Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ALDURAZYME |
| ***Drug Names*** | ALDURAZYME |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For mucopolysaccharidosis I: diagnosis was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ALECENSA |
| ***Drug Names*** | ALECENSA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer, brain metastases from ALK-positive non-small cell lung cancer. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ALOSETRON |
| ***Drug Names*** | ALOSETRON HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) Chronic IBS symptoms lasting at least 6 months AND 3) Gastrointestinal tract abnormalities have been ruled out AND 4) Inadequate response to conventional therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ALPHA1-PROTEINASE INHIBITOR |
| ***Drug Names*** | ARALAST NP, PROLASTIN-C, ZEMAIRA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema, 2) pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry), and 3) pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV1) greater than or equal to 25 percent and less than or equal to 80 percent of predicted. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ALUNBRIG |
| ***Drug Names*** | ALUNBRIG |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from NSCLC. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For metastatic or recurrent ALK-positive NSCLC: patient must have progressed on or experienced intolerance to crizotinib. For brain metastases from NSCLC: disease is ALK-positive. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ANADROL |
| ***Drug Names*** | ANADROL-50 |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Cachexia associated with AIDS (HIV-wasting) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | APOKYN |
| ***Drug Names*** | APOKYN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ARCALYST |
| ***Drug Names*** | ARCALYST |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Prevention of gout flares in patients initiating or continuing urate-lowering therapy. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For prevention of gout flares in members initiating or continuing urate-lowering therapy (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance, or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in members initiating or continuing urate-lowering therapy (continuation): 1) member must have achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | For prevention of gout flares: 4 months. Other: Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ARMODAFINIL |
| ***Drug Names*** | ARMODAFINIL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is Shift Work Disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ATYPICAL ANTIPSYCHOTICS |
| ***Drug Names*** | FANAPT, FANAPT TITRATION PACK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | AURYXIA |
| ***Drug Names*** | AURYXIA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage will be denied if request is for an indication excluded from Part D. |

| | |
|---|---|
| ***Prior Authorization Group*** | AUSTEDO |
| ***Drug Names*** | AUSTEDO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | AVASTIN |
| ***Drug Names*** | AVASTIN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, malignant pleural mesothelioma, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma types: AIDS-related Kaposi sarcoma, angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine cancer, endometrial cancer, diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma, and retinopathy of prematurity. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

| | |
|---|---|
| ***Prior Authorization Group*** | B VS. D |
| ***Drug Names*** | ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, ADRUCIL, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMINOSYN II, AMINOSYN-PF, AMINOSYN-PF 7%, AMPHOTERICIN B, APREPITANT, AZACITIDINE, AZATHIOPRINE, BENDEKA, BUDESONIDE, CALCITONIN-SALMON, CALCITRIOL, CARBOPLATIN, CINACALCET HYDROCHLORIDE, CISPLATIN, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINOLIPID, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DEPO-PROVERA, DIPHTHERIA/TETANUS TOXOID, DOCETAXEL, DOXORUBICIN HCL, DOXORUBICIN HYDROCHLORIDE, DRONABINOL, EMEND, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, FLUOROURACIL, FREAMINE HBC 6.9%, FREAMINE III, FULVESTRANT, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPATAMINE, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE HCL, IBANDRONATE SODIUM, IMOVAX RABIES (H.D.C.V.), INTRALIPID, INTRON A, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HYDROCHLORID, LEVOCARNITINE, LIDOCAINE HCL, METHOTREXATE, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MORPHINE SULFATE, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NEBUPENT, NEPHRAMINE, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON HYDROCHLORIDE, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARICALCITOL, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREMASOL, PROCALAMINE, PROGRAF, PROSOL, RABAVERT, RECOMBIVAX HB, SANDIMMUNE, SIROLIMUS, TACROLIMUS, TAXOTERE, TDVAX, TENIVAC, TOPOSAR, TPN ELECTROLYTES, TRAVASOL, TROPHAMINE, VINCRISTINE SULFATE, VINORELBINE TARTRATE, XATMEP, ZOLEDRONIC ACID, ZORTRESS |
| ***PA Indication Indicator*** | All Medically-accepted Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | N/A |
| ***Other Criteria*** | This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination. |

| | |
|---|---|
| ***Prior Authorization Group*** | BALVERSA |
| ***Drug Names*** | BALVERSA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | BANZEL |
| ***Drug Names*** | BANZEL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 1 year of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | BENLYSTA |
| ***Drug Names*** | BENLYSTA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Severe active lupus nephritis. Severe active central nervous system lupus. |
| ***Required Medical Information*** | For systemic lupus erythematosus (SLE): 1) Patient is currently receiving standard therapy (e.g., corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) for SLE OR 2) patient is not currently receiving standard therapy for SLE because patient tried and had an inadequate response or intolerance to standard therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | BERINERT |
| ***Drug Names*** | BERINERT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For hereditary angioedema (HAE): patient has hereditary angioedema with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | BETASERON |
| ***Drug Names*** | BETASERON |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | BEXAROTENE |
| ***Drug Names*** | BEXAROTENE, TARGRETIN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), chronic or smoldering adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | BOSENTAN |
| ***Drug Names*** | BOSENTAN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (PAH) (WHO Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | BOSULIF |
| ***Drug Names*** | BOSULIF |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL): Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: 1) Patient received a hematopoietic stem cell transplant, OR 2) Patient has accelerated or blast phase CML, OR 3) Patient has chronic phase CML (includes newly diagnosed) and meets one of the following conditions: a) high or intermediate risk for disease progression, or b) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | BRAFTOVI |
| ***Drug Names*** | BRAFTOVI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | BRIVIACT |
| ***Drug Names*** | BRIVIACT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 4 years of age or older (tablets and oral solution). |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | BUPRENORPHINE |
| ***Drug Names*** | BUPRENORPHINE HCL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being prescribed for the treatment of opioid dependence AND 2) The patient is pregnant or breastfeeding, and the requested drug is being prescribed for induction therapy and/or subsequent maintenance therapy for opioid dependence treatment OR 3) The requested drug is being prescribed for induction therapy for transition from opioid use to opioid dependence treatment OR 4) The requested drug is being prescribed for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 12 months |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CABOMETYX |
| ***Drug Names*** | CABOMETYX |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-small cell lung cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For renal cell carcinoma: The disease is relapsed, unresectable, or metastatic. For non-small cell lung cancer: The disease is rearranged during transfection (RET) positive. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CALCIPOTRIENE |
| ***Drug Names*** | CALCIPOTRIENE, CALCITRENE, ENSTILAR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being prescribed for the treatment of psoriasis AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic topical steroid. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CALQUENCE |
| ***Drug Names*** | CALQUENCE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CAPRELSA |
| ***Drug Names*** | CAPRELSA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For NSCLC: the requested medication is used for NSCLC with RET gene rearrangements. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CARBAGLU |
| ***Drug Names*** | CARBAGLU |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For N-acetylglutamate synthase (NAGS) deficiency: Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CAYSTON |
| ***Drug Names*** | CAYSTON |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For treatment of respiratory symptoms in cystic fibrosis patients: 1) Pseudomonas aeruginosa is present in the patient's airway cultures OR 2) The patient has a history of pseudomonas aeruginosa infection or colonization in the airways. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CERDELGA |
| ***Drug Names*** | CERDELGA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. The patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CEREZYME |
| ***Drug Names*** | CEREZYME |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Type 3 Gaucher disease |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CHANTIX |
| ***Drug Names*** | CHANTIX, CHANTIX CONTINUING MONTH, CHANTIX STARTING MONTH PA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CLOBAZAM |
| ***Drug Names*** | CLOBAZAM |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 2 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CLOMIPRAMINE |
| ***Drug Names*** | CLOMIPRAMINE HCL |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Depression, Panic Disorder |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being prescribed for one of the following: the treatment of Obsessive-Compulsive Disorder (OCD) or Panic Disorder AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI), mirtazapine OR 3) The requested drug is being prescribed for the treatment of Depression AND 4) The patient has experienced an inadequate treatment response, intolerance, or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI) , mirtazapine, bupropion |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CLORAZEPATE |
| ***Drug Names*** | CLORAZEPATE DIPOTASSIUM |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic relief in acute alcohol withdrawal OR 4) For the short-term relief of the symptoms of anxiety AND 5) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Short-term relief anxiety-1 Month, Anxiety Disorders-4 Months, All other Diagnoses-Plan Year |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored. |

| | |
|---|---|
| ***Prior Authorization Group*** | CLOZAPINE ODT |
| ***Drug Names*** | CLOZAPINE ODT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | COMETRIQ |
| ***Drug Names*** | COMETRIQ |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For NSCLC: The requested medication is used for NSCLC with RET gene rearrangements. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | COPIKTRA |
| ***Drug Names*** | COPIKTRA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | COTELLIC |
| ***Drug Names*** | COTELLIC |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Brain metastases from melanoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For melanoma (including brain metastases): 1) The disease is unresectable or metastatic, 2) The disease is positive for the BRAF V600E or V600K mutation, AND 3) The requested medication will be used in combination with vemurafenib. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CYSTAGON |
| ***Drug Names*** | CYSTAGON |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For nephropathic cystinosis: Diagnosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CYSTARAN |
| ***Drug Names*** | CYSTARAN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For treatment of corneal cystine crystal accumulation in patients with cystinosis: 1) Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing, and 2) The patient has corneal cystine crystal accumulation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | DALFAMPRIDINE |
| ***Drug Names*** | DALFAMPRIDINE ER |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For multiple sclerosis new starts: Prior to initiating therapy, patient demonstrates sustained walking impairment. For multiple sclerosis continuation of therapy: Patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting the requested medication. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | DAURISMO |
| ***Drug Names*** | DAURISMO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | DEFERASIROX |
| ***Drug Names*** | JADENU, JADENU SPRINKLE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | DEMSER |
| ***Drug Names*** | DEMSER |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | DESVENLAFAXINE |
| ***Drug Names*** | DESVENLAFAXINE ER |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following: a generic serotonin and norepinephrine reuptake inhibitor (SNRI), a generic selective serotonin reuptake inhibitor (SSRI), mirtazapine, bupropion |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | DHE NASAL |
| ***Drug Names*** | DIHYDROERGOTAMINE MESYLAT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The patient experienced an inadequate treatment response, intolerance, or contraindication to one triptan 5-HT1 receptor agonist |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | DIAZEPAM |
| ***Drug Names*** | DIAZEPAM |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For symptomatic relief in acute alcohol withdrawal OR 3) For use as an adjunct for the relief of skeletal muscle spasms OR 4) For adjunctive therapy in the treatment of convulsive disorders OR 5) For the short-term relief of the symptoms of anxiety AND 6) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Short-term relief anxiety-1 Month, Anxiety Disorders-4 Months, All other Diagnoses-Plan Year |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored |

| | |
|---|---|
| ***Prior Authorization Group*** | DICLOFENAC GEL 1% |
| ***Drug Names*** | DICLOFENAC SODIUM |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The patient has osteoarthritis pain in joints susceptible to topical treatment such as feet, ankles, knees, hands, wrists, or elbows AND 2) Treatment with the requested drug is necessary due to intolerance or a contraindication to oral nonsteroidal anti-inflammatory drugs (NSAIDs). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | EMGALITY |
| ***Drug Names*** | EMGALITY |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being prescribed for the preventive treatment of migraine in an adult patient AND 2) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 3) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 4) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants OR 1) The requested drug is being prescribed for the treatment of episodic cluster headaches in an adult patient AND 2) The patient received the requested drug for at least 3 weeks of treatment and had a reduction in weekly cluster headache attack frequency from baseline OR 3) The patient experienced an inadequate treatment response, intolerance, or contraindication to a triptan medication (i.e., 5-HT1 receptor agonist). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial 3 months, Reauthorization Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | EMSAM |
| ***Drug Names*** | EMSAM |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following antidepressants: bupropion, trazodone, mirtazapine, serotonin norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), tricyclic or tetracyclic antidepressants OR 2) Patient is unable to swallow oral formulations. |
| ***Age Restrictions*** | 18 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ENDARI |
| ***Drug Names*** | ENDARI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 5 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | EPCLUSA |
| ***Drug Names*** | EPCLUSA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Criteria will be applied consistent with current AASLD-IDSA guidance. |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | EPIDIOLEX |
| ***Drug Names*** | EPIDIOLEX |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | EPO |
| ***Drug Names*** | PROCRIT |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa), anemia in primary myelofibrosis (MF), post-polycythemia vera MF, and post-essential thrombocythemia MF. Cancer patients who are undergoing palliative treatment. |
| ***Exclusion Criteria*** | Patients receiving chemotherapy with curative intent. Patients with myeloid cancer. |
| ***Required Medical Information*** | For all uses except surgery: Pretreatment (no erythropoietin treatment in previous month) hemoglobin (Hgb) is less than 10 g/dL (less than 9 g/dL for anemia in congested heart failure only). Additional requirements for primary MF, post-polycythemia vera MF, post-essential thrombocythemia MF: 1) Patient has symptomatic anemia. 2) For initial therapy, pretreatment serum erythropoietin level is less than 500mU/mL. For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery. 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 16 weeks |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion. For reauthorizations (patient received erythropoietin in previous month): 1) For all uses except surgery, there is an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. 2) For anemia in chronic kidney disease, MDS, CHF, RA, HIV, hepatitis C treatment, primary MF, post-polycythemia vera MF, post-essential thrombocythemia MF, or patients whose religious beliefs forbid blood transfusions: current Hgb is less than or equal to 12 g/dL. 3) For anemia due to myelosuppressive cancer chemotherapy: current Hgb is less than 11 g/dL. |

| | |
|---|---|
| ***Prior Authorization Group*** | ERIVEDGE |
| ***Drug Names*** | ERIVEDGE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ERLEADA |
| ***Drug Names*** | ERLEADA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ESBRIET |
| ***Drug Names*** | ESBRIET |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For idiopathic pulmonary fibrosis (Initial Review Only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | FABRAZYME |
| ***Drug Names*** | FABRAZYME |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, or the patient is a symptomatic obligate female carrier. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | FARYDAK |
| ***Drug Names*** | FARYDAK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | FENTANYL PATCH |
| ***Drug Names*** | FENTANYL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | FETZIMA |
| ***Drug Names*** | FETZIMA, FETZIMA TITRATION PACK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Patient experienced an inadequate treatment response, intolerance, or contraindication to two generic alternatives from the following drug classes: selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | FIRAZYR |
| ***Drug Names*** | ICATIBANT ACETATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug is being used for the treatment of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER a) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR b) Patient has a family history of angioedema or the angioedema was refractory to a trial of antihistamine for at least one month. |
| ***Age Restrictions*** | 18 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | FORTEO |
| ***Drug Names*** | FORTEO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For postmenopausal osteoporosis: patient has ONE of the following (1. or 2.): 1) A history of fragility fractures, OR 2) A pre-treatment T-score of less than or equal to -2.5 or osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability and patient has ANY of the following: a) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) Patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy (e.g., injectable bisphosphonate or antiresorptive agent) OR c) Member has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has one of the following: 1) a history of osteoporotic vertebral or hip fracture, OR 2) a pre-treatment T-score of less than or equal to -2.5, OR 3) osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: 1) patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND 2) Patient has one of the following: a) a history of fragility fracture, OR b) a pre-treatment T-score of less than or equal to -2.5, OR c) osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment FRAX fracture probability. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide) |
| ***Other Criteria*** | Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture. |

| | |
|---|---|
| ***Prior Authorization Group*** | FYCOMPA |
| ***Drug Names*** | FYCOMPA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | Partial-onset seizures: 4 years of age or older, PRIMARY generalized tonic-clonic seizures: 12 years of age or older. |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | GATTEX |
| ***Drug Names*** | GATTEX |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For short bowel syndrome (SBS) initial therapy: Patient was dependent on parenteral support for at least 12 months. For SBS continuation: Requirement for parenteral support has decreased from baseline while on therapy with the requested medication. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | GILENYA |
| ***Drug Names*** | GILENYA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | GILOTRIF |
| ***Drug Names*** | GILOTRIF |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Brain metastases from non-small cell lung cancer. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): Patient meets either of the following: A) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, or B) Patient has a known sensitizing EGFR mutation. For brain metastases from NSCLC, patient has a known sensitizing EGFR mutation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | GLATIRAMER |
| ***Drug Names*** | GLATIRAMER ACETATE, GLATOPA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | First clinical episode of multiple sclerosis. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | GROWTH HORMONE |
| ***Drug Names*** | GENOTROPIN, GENOTROPIN MINIQUICK |
| ***PA Indication Indicator*** | All Medically-accepted Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Pediatric patients with closed epiphyses (except in patients with PWS). |
| ***Required Medical Information*** | Pediatric GHD: 1) Younger than 2.5 yrs old, when applicable: a) Pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2) 2.5 yrs old or older: a) Pre-tx 1-year ht velocity more than 2 SD below mean OR b) Pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean. Pediatric GHD: 1) Failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR 2) Pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) Patient is a neonate or was diagnosed with GHD as a neonate. TS: 1) Confirmed by karyotyping AND 2) Pre-treatment height is less than the 5th percentile for age. SGA: 1) Birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) Did not manifest catch-up growth by age 2. Adult GHD: 1) Failed 2 stimulation tests (peak below 5 ng/mL) or test with Macrilen (peak below 2.8 ng/ml) prior to starting tx, OR 2) Structural abnormality of the hypothalamus/pituitary AND 3 or more pituitary hormone deficiencies, OR 3) Childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS, OR 4) Low pre-tx IGF-1 and failed 1 stimulation test prior to starting tx. |
| ***Age Restrictions*** | SGA: 2 years of age or older |
| ***Prescriber Restrictions*** | Endocrinologist, pediatric endocrinologist, pediatric nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, geneticist. |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Renewal for pediatric GHD, TS, SGA, and adult GHD: patient is experiencing improvement. |

| | |
|---|---|
| ***Prior Authorization Group*** | HAEGARDA |
| ***Drug Names*** | HAEGARDA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For hereditary angioedema (HAE): The requested drug is being used for the prevention of acute angioedema attacks. Patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has HAE with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, either 1) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | HARVONI |
| ***Drug Names*** | HARVONI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Criteria applied consistent w/ current AASLD-IDSA guidance. Reminder for 8wk option if appropriate. |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | HERCEPTIN |
| ***Drug Names*** | HERCEPTIN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year. |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

| | |
|---|---|
| ***Prior Authorization Group*** | HERCEPTIN HYLECTA |
| ***Drug Names*** | HERCEPTIN HYLECTA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

| | |
|---|---|
| ***Prior Authorization Group*** | HETLIOZ |
| ***Drug Names*** | HETLIOZ |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For Non-24-Hour Sleep-Wake Disorder: 1) for initial therapy and continuation of therapy: a) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and b) unable to perceive light in both eyes, AND 2) if currently on therapy with the requested drug, patient must meet at least one of the following: a) increased total nighttime sleep or b) decreased daytime nap duration. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initiation: 6 Months, Renewal: Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | HIGH RISK MEDICATION |
| ***Drug Names*** | CYPROHEPTADINE HCL, DIGITEK, DIGOX, DIGOXIN, GUANFACINE ER, SCOPOLAMINE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |

| | |
|---|---|
| ***Prior Authorization Group*** | HRM-ANTICONVULSANTS |
| ***Drug Names*** | PHENOBARBITAL, PHENOBARBITAL SODIUM |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |

| | |
|---|---|
| ***Prior Authorization Group*** | HRM-ANTIPARKINSON |
| ***Drug Names*** | BENZTROPINE MESYLATE, TRIHEXYPHENIDYL HCL, TRIHEXYPHENIDYL HYDROCHLO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) EPS (extrapyramidal symptoms): 1) The patient has not tried the non-HRM alternative drug amantadine AND 2) The patient has a contraindication to the non-HRM alternative drug amantadine AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient OR 4) The patient has tried the non-HRM alternative drug amantadine AND 5) The patient experienced an inadequate treatment response OR intolerance to the non-HRM alternative drug amantadine AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient. Parkinson's: 1) The patient has tried two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole have been tried. AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient. |

| | |
|---|---|
| ***Prior Authorization Group*** | HRM-GLYBURIDE |
| ***Drug Names*** | GLYBURIDE, GLYBURIDE MICRONIZED, GLYBURIDE/METFORMIN HYDRO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) The patient has not tried one of the following non-HRM alternative drugs: glipizide or metformin AND 2) The patient has a contraindication to one of the following non-HRM alternative drugs: glipizide or metformin AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient OR 4) The patient has tried one of the following non-HRM alternative drugs: glipizide or metformin AND 5) The patient experienced an inadequate treatment response OR intolerance to one of the following non-HRM alternative drugs: glipizide or metformin AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient. |

| | |
|---|---|
| ***Prior Authorization Group*** | HRM-HYDROXYZINE |
| ***Drug Names*** | HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE, HYDROXYZINE PAMOATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release have been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient OR 4) If being requested for pruritus, prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient. |

| | |
|---|---|
| ***Prior Authorization Group*** | HRM-HYDROXYZINE INJ |
| ***Drug Names*** | HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Alcohol Withdrawal Syndrome: 1) The patient has not tried one of the following alternative drugs: clorazepate or lorazepam AND 2) The patient has a contraindication to one of the following alternative drugs: clorazepate or lorazepam AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient OR 4) The patient has tried one of the following alternative drugs: clorazepate or lorazepam AND 5) The patient experienced an inadequate treatment response OR intolerance to one of the following alternative drugs: clorazepate or lorazepam AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient. Anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient OR 4) If being requested for nausea/vomiting, prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient. |

| | |
|---|---|
| ***Prior Authorization Group*** | HRM-HYPNOTICS |
| ***Drug Names*** | ESZOPICLONE, ZALEPLON, ZOLPIDEM TARTRATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) The patient has a contraindication to two of the following non-HRM alternative drugs: Silenor (3mg or 6mg) and trazodone AND 2) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 3) One non-HRM alternative drug Silenor (3mg or 6mg) or trazodone has been tried AND 4) The patient experienced an inadequate treatment response OR intolerance to one of the following non-HRM alternative drugs: Silenor (3mg or 6mg) or trazodone AND 5) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR. |

| | |
|---|---|
| ***Prior Authorization Group*** | HRM-PROMETHAZINE |
| ***Drug Names*** | PROMETHAZINE HCL, PROMETHAZINE HCL PLAIN, PROMETHAZINE HYDROCHLORID |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Rhinitis: 1) The patient has tried one of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to one of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The requested drug is being prescribed for urticaria AND 5) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 6) The drug is being requested for antiemetic therapy in postoperative patients or motion sickness AND 7) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 8) The requested drug is being prescribed for any of the following: allergic conjunctivitis, dermatographism, allergic reaction to blood or plasma, sedation, adjunct therapy with analgesics for postoperative pain, angioedema, or adjunct therapy with epinephrine for anaphylaxis after acute symptoms are controlled AND 9) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |

| | |
|---|---|
| ***Prior Authorization Group*** | HRM-SKELETAL MUSCLE RELAXANTS |
| ***Drug Names*** | CARISOPRODOL, CYCLOBENZAPRINE HYDROCHLO, METHOCARBAMOL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient. |

| | |
|---|---|
| ***Prior Authorization Group*** | HUMIRA |
| ***Drug Names*** | HUMIRA, HUMIRA PEDIATRIC CROHNS D, HUMIRA PEN, HUMIRA PEN-CD/UC/HS START, HUMIRA PEN-PS/UV STARTER |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Axial spondyloarthritis. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD (e.g., tofacitinib). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to MTX OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy. For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates), OR 2) Intolerance or contraindication to conventional therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | HYPNOTIC BENZODIAZEPINES |
| ***Drug Names*** | TEMAZEPAM |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) One non-HRM (non-High Risk Medication) alternative drug Silenor (3 mg or 6 mg) or trazodone has been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to one non-HRM (non-High Risk Medication) alternative drug Silenor (3 mg or 6 mg) or trazodone OR 3) The patient has a contraindication to two non-HRM (non-High Risk Medication) alternative drugs Silenor (3 mg or 6 mg) and trazodone AND 4)The benefit of therapy with this prescribed medication outweighs the potential risk in a patient 65 years of age or older APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR. |

| | |
|---|---|
| ***Prior Authorization Group*** | IBRANCE |
| ***Drug Names*** | IBRANCE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Well-differentiated/dedifferentiated liposarcoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ICLUSIG |
| ***Drug Names*** | ICLUSIG |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Follow-up therapy after hematopoietic stem cell transplant (HSCT) for CML and ALL patients. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | IDHIFA |
| ***Drug Names*** | IDHIFA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | IMATINIB |
| ***Drug Names*** | IMATINIB MESYLATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, melanoma, and AIDS-related Kaposi sarcoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For melanoma, c-Kit mutation is positive. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | IMBRUVICA |
| ***Drug Names*** | IMBRUVICA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, hairy cell leukemia, and lymphoplasmacytic lymphoma, follicular lymphoma, primary central nervous system lymphoma, AIDS-related B-cell lymphoma, histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma, diffuse large B-cell lymphoma, post-transplant lymphoproliferative disorders. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For mantle cell lymphoma: 1) the requested drug will be used in a patient who has received at least one prior therapy, OR 2) the requested drug will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen. For gastric MALT lymphoma and non-gastric MALT lymphoma: 1) disease is recurrent, refractory, or progressive, AND 2) the requested drug will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary central nervous system lymphoma: the disease is relapsed or refractory disease. For nodal marginal zone lymphoma or splenic marginal zone lymphoma: 1) disease is refractory or progressive, AND 2) the requested drug will be used as second-line or subsequent therapy. For histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma: the requested drug will be used in patients who have received prior chemoimmunotherapy. For diffuse large B-cell lymphoma: 1) disease is progressive or refractory AND 2) the requested drug will be used as second-line or subsequent therapy. For AIDS-related B-cell lymphoma: the requested drug will be used as second-line or subsequent therapy for relapsed disease. For post-transplant lymphoproliferative disorders: 1) the disease is partially responsive, persistent, or progressive AND 2) the requested drug will be used in patients who have received prior chemoimmunotherapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | INCRELEX |
| ***Drug Names*** | INCRELEX |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone gene deletion in patients who have developed neutralizing antibodies to growth hormone, must meet all of the following prior to beginning therapy with the requested drug (new starts only): 1) height 3 or more standard deviations below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | For renewal, patient is experiencing improvement. |

| | |
|---|---|
| ***Prior Authorization Group*** | INLYTA |
| ***Drug Names*** | INLYTA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Papillary, Hurthle cell, or follicular thyroid carcinoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For renal cell carcinoma, the disease is relapsed, metastatic, or unresectable. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | INREBIC |
| ***Drug Names*** | INREBIC |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | IR BEFORE ER |
| ***Drug Names*** | HYSINGLA ER, METHADONE HCL, METHADONE HCL INTENSOL, MORPHINE SULFATE ER, NUCYNTA ER |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 5) The request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has severe continuous pain and the patient has received an immediate-release opioid for at least one week |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | IRESSA |
| ***Drug Names*** | IRESSA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Brain metastases from non-small cell lung cancer. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC) (including brain metastases from NSCLC), patient has a known sensitizing EGFR mutation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ISOTRETINOIN |
| ***Drug Names*** | AMNESTEEM, CLARAVIS, ISOTRETINOIN, MYORISAN, ZENATANE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Refractory acne, severe refractory rosacea, neuroblastoma, cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), high risk for developing skin cancer (squamous cell cancers), transient acantholytic dermatosis (Grover's Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, pityriasis rubra pilaris. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ITRACONAZOLE |
| ***Drug Names*** | ITRACONAZOLE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Coccidioidomycosis, Cryptococcosis, Microsporidiosis, Penicilliosis, Sporotrichosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea capitis, Tinea manuum/Tinea pedis. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed by a fungal diagnostic test. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | IVIG |
| ***Drug Names*** | BIVIGAM, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PANZYGA, PRIVIGEN |
| ***PA Indication Indicator*** | All Medically-accepted Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For CLL: 1) serum IgG less than 500 mg/dL OR 2) a history of recurrent bacterial infections. For BMT/HSCT: 1) IVIG is requested within the first 100 days post-transplant OR 2) serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL, OR 2) History of recurrent bacterial infections. For dermatomyositis and polymyositis: 1) at least one standard first-line treatment (corticosteroids or immunosuppressants) has been tried but was unsuccessful or not tolerated OR 2) patient is unable to receive standard therapy because of a contraindication or other clinical reason. For PRCA: PRCA is secondary to parvovirus B19 infection. For management of immune checkpoint inhibitor-related nervous system adverse events: 1) Patient has experienced a moderate or severe adverse event to a PD-1 or PD-L1 inhibitor, 2) IVIG is requested to manage one or more of the following nervous system adverse event types: pneumonitis, myasthenia gravis, peripheral neuropathy, encephalitis or transverse myelitis, and 3) the offending medication is temporarily being held or has been discontinued. |
| ***Age Restrictions*** | For pediatric HIV infection: age 12 years or younger. |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

| | |
|---|---|
| ***Prior Authorization Group*** | JAKAFI |
| ***Drug Names*** | JAKAFI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Low-risk, accelerated phase, or blast phase myelofibrosis |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For polycythemia vera: patients with inadequate response or intolerance to interferon therapy or hydroxyurea. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | JUXTAPID |
| ***Drug Names*** | JUXTAPID |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For initiation of therapy to treat homozygous familial hypercholesterolemia: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), AND 2) Prior to initiation of treatment with the requested drug, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin, fibrate, bile acid sequestrant, ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the Food and Drug Administration (FDA), AND 3) Prior to initiation of treatment with the requested drug, patient is/was experiencing an inadequate response to such combination regimen as demonstrated by treated low-density lipoprotein cholesterol (LDL-C) greater than 100 mg/dL (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). For renewal of therapy to treat HoFH: 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, apolipoprotein B (ApoB), proprotein convertase subtilisin/kexin type 9 (PCSK9), or LDL receptor adaptor protein/ARH gene locus, OR 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, or b) Diagnosis of familial hypercholesterolemia (FH) by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature atherosclerotic cardiovascular disease (ASCVD) [before 55 years in men and 60 years in women], tendon xanthoma, or sudden premature cardiac death. Diagnosis of FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, or 2) Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or family history of myocardial infarction in a first degree relative before the age 60 or in a second degree relative before age 50, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 points. |

| | |
|---|---|
| ***Prior Authorization Group*** | KALYDECO |
| ***Drug Names*** | KALYDECO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystic fibrosis: The patient has one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation. |
| ***Age Restrictions*** | 6 months of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | The requested drug will not be used in combination with lumacaftor/ivacaftor or tezacaftor/ivacaftor. |

| | |
|---|---|
| ***Prior Authorization Group*** | KETOCONAZOLE |
| ***Drug Names*** | KETOCONAZOLE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Cushing's syndrome. |
| ***Exclusion Criteria*** | Acute or chronic liver disease. Current use with dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, alprazolam or simvastatin. |
| ***Required Medical Information*** | 1) Patient has one of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis, OR 2) The requested drug is being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or surgery has not been curative. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | KEYTRUDA |
| ***Drug Names*** | KEYTRUDA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer, uveal melanoma, esophageal and esophagogastric junction cancers, Ewing's sarcoma, osteosarcoma, testicular cancer, endometrial carcinoma, anal carcinoma, adrenal gland tumors, penile cancer, central nervous system (CNS) brain metastases in patients with melanoma or non-small cell lung cancer (NSCLC), Non-Hodgkin's lymphoma, pancreatic adenocarcinoma, hepatobiliary cancers (extrahepatic cholangiocarcinoma, intrahepatic cholangiocarcinoma, gallbladder cancer). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | KISQALI |
| ***Drug Names*** | KISQALI, KISQALI FEMARA 200 DOSE, KISQALI FEMARA 400 DOSE, KISQALI FEMARA 600 DOSE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For breast cancer: The requested drug is used in combination with an aromatase inhibitor, fulvestrant, or tamoxifen. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | KORLYM |
| ***Drug Names*** | KORLYM |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | KUVAN |
| ***Drug Names*** | KUVAN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For phenylketonuria: For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment, including before dietary management, phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced a reduction in blood phenylalanine level of greater than or equal to 30 percent from baseline OR the patient has demonstrated an improvement in neuropsychiatric symptoms. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial: 2 months. All others: Plan Year. |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | LENVIMA |
| ***Drug Names*** | LENVIMA 10 MG DAILY DOSE, LENVIMA 12MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 4 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Medullary thyroid carcinoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | LETAIRIS |
| ***Drug Names*** | AMBRISENTAN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | LIDOCAINE PATCHES |
| ***Drug Names*** | LIDOCAINE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | LONSURF |
| ***Drug Names*** | LONSURF |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For colorectal cancer: The disease is unresectable advanced or metastatic. Patient has progressed on treatment with EITHER a) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR b) irinotecan- AND oxaliplatin-based regimens. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | LORBRENA |
| ***Drug Names*** | LORBRENA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | LUMIZYME |
| ***Drug Names*** | LUMIZYME |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For Pompe disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | LUPRON |
| ***Drug Names*** | LEUPROLIDE ACETATE, LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH), LUPRON DEPOT-PED (1-MONTH, LUPRON DEPOT-PED (3-MONTH |
| ***PA Indication Indicator*** | All Medically-accepted Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For central precocious puberty (CPP), patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP confirmed by: a) a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay AND b) Assessment of bone age versus chronological age, and 2) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. For uterine fibroids, patient must meet one of the following: 1) Diagnosis of anemia (eg, hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) the requested medication will be used prior to surgery for uterine fibroids. |
| ***Age Restrictions*** | CPP: Patient must be less than 12 years old if female and less than 13 years old if male. |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | LYNPARZA |
| ***Drug Names*** | LYNPARZA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For HER2-negative, recurrent or metastatic breast cancer, patient must have a deleterious or suspected deleterious germline BRCA mutation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | LYRICA CR |
| ***Drug Names*** | LYRICA CR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | MAVYRET |
| ***Drug Names*** | MAVYRET |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C). |
| ***Required Medical Information*** | For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Criteria will be applied consistent with current AASLD-IDSA guidance. |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | MEGESTROL |
| ***Drug Names*** | MEGESTROL ACETATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | MEKINIST |
| ***Drug Names*** | MEKINIST |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Brain metastases from melanoma, uveal melanoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For brain metastasis from melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with dabrafenib. For adjuvant treatment of melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with dabrafenib. For unresectable or metastatic melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used as a single agent or in combination with dabrafenib. For non-small cell lung cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used in combination with dabrafenib. For anaplastic thyroid cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used in combination with dabrafenib. For uveal melanoma, the requested drug will be used as a single agent. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | MEKTOVI |
| ***Drug Names*** | MEKTOVI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | MEMANTINE |
| ***Drug Names*** | MEMANTINE HCL, MEMANTINE HCL TITRATION P, MEMANTINE HYDROCHLORIDE, MEMANTINE HYDROCHLORIDE E |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This edit only applies to patients less than 30 years of age. |

| | |
|---|---|
| ***Prior Authorization Group*** | MIGLUSTAT |
| ***Drug Names*** | MIGLUSTAT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For Gaucher disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NAGLAZYME |
| ***Drug Names*** | NAGLAZYME |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Diagnosis of mucopolysaccharidosis VI disease was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NATPARA |
| ***Drug Names*** | NATPARA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Acute postsurgical hypoparathyroidism (within 6 months of surgery) and expected recovery from the hypoparathyroidism. |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NERLYNX |
| ***Drug Names*** | NERLYNX |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Brain metastases. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For Breast cancer: the requested medication is initiated after completing adjuvant trastuzumab based therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NEXAVAR |
| ***Drug Names*** | NEXAVAR |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Acute myeloid leukemia, soft tissue sarcoma (angiosarcoma, desmoid tumors/aggressive fibromatosis, gastrointestinal stromal tumor, solitary fibrous tumor, and hemangiopericytoma subtypes), medullary thyroid carcinoma, osteosarcoma, chordoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For thyroid carcinoma: histology is follicular, papillary, Hurthle cell or medullary. For acute myeloid leukemia: 1) the disease is relapsed or refractory, and 2) the patient has FLT3-ITD mutation-positive disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NINLARO |
| ***Drug Names*** | NINLARO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For multiple myeloma: The requested drug will be used in combination with lenalidomide and dexamethasone OR pomalidomide and dexamethasone OR dexamethasone. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NITYR |
| ***Drug Names*** | NITYR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For hereditary tyrosinemia type 1: Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NORTHERA |
| ***Drug Names*** | NORTHERA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Prior to initial therapy for neurogenic orthostatic hypotension (NOH), patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing. For continuation of therapy for NOH, patient must experience a sustained decrease in dizziness. For both initial and continuation of therapy for NOH, the requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) Primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) Dopamine beta hydroxylase deficiency, OR 3) Non-diabetic autonomic neuropathy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NUBEQA |
| ***Drug Names*** | NUBEQA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NUCALA |
| ***Drug Names*** | NUCALA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For initial therapy for severe asthma with an eosinophilic phenotype: 1) Patient has baseline blood eosinophil count of at least 150 cells per microliter, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications at optimized doses: a) inhaled corticosteroid and b) additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline). For continuation therapy for severe asthma with an eosinophilic phenotype: Asthma control has improved on treatment with the requested drug, demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For initial therapy for eosinophilic granulomatosis with polyangiitis (EGPA): Patient has a history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level greater than 10 percent. For continuation of therapy for EGPA: Patient has a beneficial response to treatment with the requested drug, demonstrated by any of the following: 1) a reduction in the frequency of relapses, 2) a reduction in the daily oral corticosteroid dose, or 3) no active vasculitis. |
| ***Age Restrictions*** | Asthma: 12 years of age or older, EGPA: 18 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NUEDEXTA |
| ***Drug Names*** | NUEDEXTA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NUPLAZID |
| ***Drug Names*** | NUPLAZID |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | OCTREOTIDE |
| ***Drug Names*** | OCTREOTIDE ACETATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Meningiomas, thymomas and thymic carcinomas, and neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, and pancreas. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acromegaly (initial): 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For meningiomas: patient has unresectable disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | For acromegaly (continuation of therapy): patient's IGF-1 level has decreased or normalized since initiation of therapy. |

| | |
|---|---|
| ***Prior Authorization Group*** | ODOMZO |
| ***Drug Names*** | ODOMZO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | OFEV |
| ***Drug Names*** | OFEV |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For idiopathic pulmonary fibrosis (Initial Review Only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | OPSUMIT |
| ***Drug Names*** | OPSUMIT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ORAL-INTRANASAL FENTANYL |
| ***Drug Names*** | FENTANYL CITRATE ORAL TRA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is indicated for the treatment of breakthrough CANCER-related pain only. The requested drug is being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain. [Note: Ensure that the patient is opioid tolerant. Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 60 mg oral hydrocodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg oral oxymorphone per day, or an equianalgesic dose of another opioid medication daily for a week or longer.] AND 2) The International Classification of Diseases (ICD) diagnosis code provided supports the CANCER-RELATED diagnosis. [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER-RELATED diagnosis.] |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ORFADIN |
| ***Drug Names*** | ORFADIN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For hereditary tyrosinemia type 1: Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ORKAMBI |
| ***Drug Names*** | ORKAMBI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystic fibrosis: the patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene. |
| ***Age Restrictions*** | 2 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | The requested drug will not be used in combination with ivacaftor or tezacaftor/ivacaftor. |

| | |
|---|---|
| ***Prior Authorization Group*** | OXANDROLONE |
| ***Drug Names*** | OXANDROLONE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Cachexia associated with AIDS (HIV-wasting) or to enhance growth in patients with Turner's Syndrome. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | Coverage will be denied if request is for an indication excluded from Part D. |

| | |
|---|---|
| ***Prior Authorization Group*** | PEGASYS |
| ***Drug Names*** | PEGASYS, PEGASYS PROCLICK |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, primary myelofibrosis and post-polycythemia vera or post-essential thrombocythemia myelofibrosis) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | HCV=Criteria will be applied consistent with current AASLD-IDSA guidance. HBV=48 wks. Other=Plan Yr |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | PHENYLBUTYRATE |
| ***Drug Names*** | SODIUM PHENYLBUTYRATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For urea cycle disorder: Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | PIQRAY |
| ***Drug Names*** | PIQRAY 200MG DAILY DOSE, PIQRAY 250MG DAILY DOSE, PIQRAY 300MG DAILY DOSE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | POMALYST |
| ***Drug Names*** | POMALYST |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Systemic light chain amyloidosis, acquired immunodeficiency syndrome (AIDS)-related Kaposi sarcoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For multiple myeloma: The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent AND a proteasome inhibitor. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | PRALUENT |
| ***Drug Names*** | PRALUENT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | PREGABALIN |
| ***Drug Names*** | PREGABALIN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Cancer-related neuropathic pain, cancer treatment related neuropathic pain. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being prescribed for the management of postherpetic neuralgia, neuropathic pain associated with diabetic peripheral neuropathy, cancer-related neuropathic pain or cancer treatment related neuropathic pain AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to gabapentin OR 3) The requested drug is being prescribed as adjunctive therapy for partial onset seizures OR 4) The requested drug is being prescribed for the management of fibromyalgia or management of neuropathic pain associated with spinal cord injury. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | PROMACTA |
| ***Drug Names*** | PROMACTA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to prior therapy such as corticosteroids or immunoglobulins, AND b) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) For continuation of therapy, platelet (plt) count response to the requested drug: a) Current plt count is less than or equal to 200,000/mcL OR b) Current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): For continuation of therapy following the initial 6 month approval for severe aplastic anemia: The patient must meet one of the following: 1) Current plt count is 50,000-200,000/mcL OR 2) Current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and patient is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks |
| ***Other Criteria*** | APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL) |

| | |
|---|---|
| ***Prior Authorization Group*** | PULMOZYME |
| ***Drug Names*** | PULMOZYME |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystic fibrosis: Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

| | |
|---|---|
| ***Prior Authorization Group*** | QUETIAPINE XR |
| ***Drug Names*** | QUETIAPINE FUMARATE ER |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Maintenance monotherapy treatment in bipolar I disorder, monotherapy treatment of generalized anxiety disorder, monotherapy treatment of major depressive disorder |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For schizophrenia, acute treatment of manic or mixed episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex, the acute treatment of depressive episodes associated with bipolar disorder, maintenance treatment of bipolar I disorder, as an adjunct to lithium or divalproex, adjunctive treatment of major depressive disorder, or maintenance monotherapy treatment in bipolar I disorder: The patient has had an inadequate treatment response, intolerance or contraindication to one of the following: aripiprazole, lurasidone, olanzapine, paliperidone, quetiapine immediate-release, risperidone, or ziprasidone |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | QUININE SULFATE |
| ***Drug Names*** | QUININE SULFATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Babesiosis, uncomplicated Plasmodium vivax malaria. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 1 month |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | REGRANEX |
| ***Drug Names*** | REGRANEX |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 20 weeks |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | RELISTOR INJ |
| ***Drug Names*** | RELISTOR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being prescribed for opioid-induced constipation in an adult patient with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care OR 2) The requested drug is being prescribed for opioid-induced constipation in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has been tried. (Note: Examples are Amitiza or Movantik) AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain. (Note: Examples are Amitiza or Movantik) OR 6) The patient has a contraindication to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (Note: Examples are Amitiza or Movantik). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 4 months |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | REMICADE |
| ***Drug Names*** | REMICADE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Axial spondyloarthritis, Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor. For juvenile idiopathic arthritis (new starts only): Inadequate response or intolerance to a self-injectable TNF inhibitor. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | RENFLEXIS |
| ***Drug Names*** | RENFLEXIS |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Axial spondyloarthritis, Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor. For juvenile idiopathic arthritis (new starts only): Inadequate response or intolerance to a self-injectable TNF inhibitor. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | REVLIMID |
| ***Drug Names*** | REVLIMID |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, myelofibrosis-associated anemia, POEMS syndrome, non-Hodgkin's lymphoma with the following subtypes: AIDS-related diffuse large B-cell lymphoma, primary central nervous system (CNS) lymphoma, monomorphic post-transplant lymphoproliferative disorder, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), diffuse large B-cell lymphoma, nongastric/gastric mucosa associated lymphoid tissue (MALT) lymphoma, primary cutaneous B-cell lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, mycosis fungoides (MF)/Sezary syndrome (SS), angioimmunoblastic T-cell lymphoma (AITL), peripheral T-cell lymphoma not otherwise specified (PTCL NOS), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, follicular T-cell lymphoma, primary cutaneous anaplastic large cell lymphoma (ALCL). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For myelodysplastic syndrome (MDS): Low- to intermediate-1 risk MDS with symptomatic anemia |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | RITUXAN |
| ***Drug Names*** | RITUXAN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric MALT, nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, Castleman's disease, AIDS-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD)], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary CNS lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, and idiopathic refractory inflammatory myopathy |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active rheumatoid arthritis (new starts only): A) the requested medication is used in combination with methotrexate (MTX) unless MTX is contraindicated or not tolerated, AND B) patient has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). Hematologic malignancies must be CD20-positive. For multiple sclerosis: A) patient has a diagnosis of relapsing remitting multiple sclerosis and B) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | RITUXAN HYCELA |
| ***Drug Names*** | RITUXAN HYCELA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Acquired immune deficiency syndrome (AIDS)-related B-cell lymphoma, Burkitt lymphoma, Castleman's disease (CD), small lymphocytic lymphoma (SLL), gastric MALT lymphoma, mantle cell lymphoma, nodal marginal zone lymphoma, nongastric MALT lymphoma, primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas), post-transplant lymphoproliferative disorder (PTLD), splenic marginal zone lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | RUBRACA |
| ***Drug Names*** | RUBRACA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | RYDAPT |
| ***Drug Names*** | RYDAPT |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Relapsed or refractory acute myeloid leukemia |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acute myeloid leukemia (AML), AML must be FLT3 mutation-positive. |
| ***Age Restrictions*** | 18 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | SIGNIFOR |
| ***Drug Names*** | SIGNIFOR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | SILDENAFIL |
| ***Drug Names*** | SILDENAFIL CITRATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | SIRTURO |
| ***Drug Names*** | SIRTURO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | The requested drug is not being prescribed for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis, or infection caused by the non-tuberculous mycobacteria |

| | |
|---|---|
| ***Prior Authorization Group*** | SOMATULINE DEPOT |
| ***Drug Names*** | SOMATULINE DEPOT |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, and pancreas |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acromegaly (initial): 1) patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy. |

| | |
|---|---|
| ***Prior Authorization Group*** | SOMAVERT |
| ***Drug Names*** | SOMAVERT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acromegaly (initial): 1) patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy. |

| | |
|---|---|
| ***Prior Authorization Group*** | SPRYCEL |
| ***Drug Names*** | SPRYCEL |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Gastrointestinal stromal tumor (GIST) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) For chronic phase CML, patient has one of the following a) patient is 21 years of age or younger, or b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib, or regorafenib. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | STELARA |
| ***Drug Names*** | STELARA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderate to severe plaque psoriasis (new starts only): 1) at least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) the patient had an inadequate response, intolerance, or contraindication to Humira. For active psoriatic arthritis (PsA) (new starts only): the patient had an inadequate response, intolerance, or contraindication to Humira or Xeljanz/Xeljanz XR. For moderately to severely active Crohn's disease (new starts only): patient had an inadequate response, intolerance, or contraindication to Humira. |
| ***Age Restrictions*** | Plaque psoriasis: 12 years of age or older. All other indications: 18 years of age or older. |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | STIVARGA |
| ***Drug Names*** | STIVARGA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Progressive gastrointestinal stromal tumors (GIST) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For colorectal cancer: The disease is unresectable, advanced, or metastatic. The patient has progressed on treatment with EITHER 1) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR 2) irinotecan- AND oxaliplatin-based regimens. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | SUTENT |
| ***Drug Names*** | SUTENT |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, and hemangiopericytoma subtypes), chordoma, thymic carcinoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For renal cell carcinoma: Either 1) The disease is relapsed, metastatic, or unresectable, OR 2) The patient is at high risk of disease recurrence following nephrectomy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | SYLATRON |
| ***Drug Names*** | SYLATRON |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Myelofibrosis, polycythemia vera, essential thrombocythemia, systemic mastocytosis. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | SYMDEKO |
| ***Drug Names*** | SYMDEKO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystic fibrosis (CF): The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene OR the patient has a mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation |
| ***Age Restrictions*** | 6 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Symdeko will not be used in combination with Orkambi or Kalydeco. |

| | |
|---|---|
| ***Prior Authorization Group*** | SYMPAZAN |
| ***Drug Names*** | SYMPAZAN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 2 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | SYNRIBO |
| ***Drug Names*** | SYNRIBO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Follow-up therapy for CML patients after hematopoietic stem cell transplant (HSCT), treatment of chronic CML patients with a T315I mutation. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TAFINLAR |
| ***Drug Names*** | TAFINLAR |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Brain metastases from melanoma, thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For brain metastases from melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with trametinib. For adjuvant treatment of melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with trametinib. For unresectable or metastatic melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used as a single agent or in combination with trametinib. For non-small cell lung cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used as a single agent or in combination with trametinib. For thyroid carcinoma, the tumor is positive for BRAF activating mutation with papillary, follicular, or Hurthle histology. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TAGRISSO |
| ***Drug Names*** | TAGRISSO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent or metastatic non-small cell lung cancer, brain metastases from non-small cell lung cancer. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For metastatic or recurrent non-small cell lung cancer (NSCLC), patient must have sensitizing EGFR mutation-positive NSCLC (including brain metastases from non-small cell lung cancer). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TALZENNA |
| ***Drug Names*** | TALZENNA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TARCEVA |
| ***Drug Names*** | ERLOTINIB HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Chordoma, renal cell carcinoma (RCC), brain metastases from non-small cell lung cancer (NSCLC). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For NSCLC (including brain metastases from NSCLC), patient has a known sensitizing EGFR mutation. For pancreatic cancer, the disease is locally advanced, unresectable, or metastatic. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TASIGNA |
| ***Drug Names*** | TASIGNA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) For chronic phase CML, the patient has one of the following: a) patient is 18 years of age or younger, b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TAZAROTENE |
| ***Drug Names*** | TAZAROTENE, TAZORAC |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For plaque psoriasis, the requested drug is being prescribed to treat less than 20 percent of the patient's body surface area. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TECENTRIQ |
| ***Drug Names*** | TECENTRIQ |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer, patient meets one of the following: 1) The disease has progressed during or following cytotoxic chemotherapy, 2) Patient has positive epidermal growth factor receptor (EGFR) mutation, positive anaplastic lymphoma kinase (ALK), or positive c-ros oncogene 1 (ROS1) gene rearrangement and has had disease progression on targeted FDA-approved therapy (e.g., erlotinib, afatinib, gefitinib, crizotinib, ceritinib) prior to receiving the requested drug, OR 3) Patient has non-squamous histology and has negative epidermal growth factor receptor (EGFR), negative anaplastic lymphoma kinase (ALK), negative c-ros oncogene 1 (ROS1) non-small cell lung cancer. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TESTOSTERONE CYPIONATE INJ |
| ***Drug Names*** | TESTOSTERONE CYPIONATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Gender Dysphoria in transgender male patients |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 3) Requested drug is being prescribed for gender dysphoria in a transgender male patient who is able to make an informed, mature decision to engage in therapy |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TESTOSTERONE ENANTHATE INJ |
| ***Drug Names*** | TESTOSTERONE ENANTHATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Gender Dysphoria in transgender male patients. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 3) Requested drug is being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal and who has had an incomplete response to other therapy for metastatic breast cancer OR 4) Requested drug is being prescribed for a premenopausal patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor OR 5) Requested drug is being prescribed for delayed puberty in a male patient OR 6) Requested drug is being prescribed for gender dysphoria in a transgender male patient who is able to make an informed, mature decision to engage in therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TETRABENAZINE |
| ***Drug Names*** | TETRABENAZINE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Chronic tics, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For treatment of chorea associated with Huntington's disease and tardive dyskinesia: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | THALOMID |
| ***Drug Names*** | THALOMID |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Myelofibrosis-related anemia, recurrent aphthous stomatitis, recurrent HIV-associated aphthous ulcers, cachexia, human immunodeficiency virus (HIV)-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cachexia: Cachexia must be due to cancer or human immunodeficiency virus (HIV) infection. For Kaposi's sarcoma: The patient has human immunodeficiency virus (HIV) infection. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TIBSOVO |
| ***Drug Names*** | TIBSOVO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TOBRAMYCIN |
| ***Drug Names*** | TOBRAMYCIN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-cystic fibrosis bronchiectasis |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystic fibrosis and non-cystic fibrosis bronchiectasis, the patient must meet one of the following: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) the patient has a history of Pseudomonas aeruginosa infection or colonization in the airways. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

| | |
|---|---|
| ***Prior Authorization Group*** | TOPICAL LIDOCAINE |
| ***Drug Names*** | GLYDO, LIDOCAINE, LIDOCAINE HCL, LIDOCAINE HCL JELLY, LIDOCAINE/PRILOCAINE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being used for topical anesthesia, 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are FDA-approved for topical use |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

| | |
|---|---|
| ***Prior Authorization Group*** | TOPICAL TESTOSTERONES |
| ***Drug Names*** | ANDRODERM, TESTOSTERONE, TESTOSTERONE PUMP |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Gender Dysphoria in transgender male patients. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 3) Requested drug is being prescribed for gender dysphoria in a transgender male patient who is able to make an informed, mature decision to engage in therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TOPICAL TRETINOIN |
| ***Drug Names*** | AVITA, TRETINOIN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TRELSTAR |
| ***Drug Names*** | TRELSTAR MIXJECT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TREPROSTINIL INJ |
| ***Drug Names*** | TREPROSTINIL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only, the patient must meet all of the following: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

| | |
|---|---|
| ***Prior Authorization Group*** | TRIENTINE |
| ***Drug Names*** | TRIENTINE HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TRINTELLIX |
| ***Drug Names*** | TRINTELLIX |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Patient experienced an inadequate treatment response, intolerance, or contraindication to two generic alternatives from the following drug classes: selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TURALIO |
| ***Drug Names*** | TURALIO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TYKERB |
| ***Drug Names*** | TYKERB |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Metastatic CNS lesions from HER2-positive breast cancer, recurrent EGFR-positive chordoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For HER2-positive breast cancer, the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TYMLOS |
| ***Drug Names*** | TYMLOS |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For postmenopausal osteoporosis: patient has ONE of the following: 1) a history of fragility fractures, OR 2) a pre-treatment T-score of less than or equal to -2.5 or osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide) |
| ***Other Criteria*** | Patient has high Fracture Risk Assessment Tool (FRAX) fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture. |

| | |
|---|---|
| ***Prior Authorization Group*** | VALCHLOR |
| ***Drug Names*** | VALCHLOR |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Chronic or smoldering adult T-cell leukemia/lymphoma, Stage 2 or higher mycosis fungoides/Sezary syndrome, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | VELCADE |
| ***Drug Names*** | BORTEZOMIB, VELCADE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

| | |
|---|---|
| ***Prior Authorization Group*** | VENCLEXTA |
| ***Drug Names*** | VENCLEXTA, VENCLEXTA STARTING PACK |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Mantle cell lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For AML, patient meets any of the following: 1) the patient is 60 years of age or older, OR 2) the requested drug will be used as a component of repeating the initial successful induction regimen if late relapse, OR 3) the patient has comorbidities that preclude use of intensive induction chemotherapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | VENTAVIS |
| ***Drug Names*** | VENTAVIS |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only, the patient must meet all of the following: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

| | |
|---|---|
| ***Prior Authorization Group*** | VERSACLOZ |
| ***Drug Names*** | VERSACLOZ |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | VERZENIO |
| ***Drug Names*** | VERZENIO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | VIGABATRIN |
| ***Drug Names*** | VIGABATRIN, VIGADRONE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For complex partial seizures (CPS): patient had an inadequate response to at least 2 alternative therapies for CPS. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | VIIBRYD |
| ***Drug Names*** | VIIBRYD, VIIBRYD STARTER PACK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Patient experienced an inadequate treatment response, intolerance, or contraindication to two generic alternatives from the following drug classes: selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | VITRAKVI |
| ***Drug Names*** | VITRAKVI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | VIZIMPRO |
| ***Drug Names*** | VIZIMPRO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | VORICONAZOLE |
| ***Drug Names*** | VORICONAZOLE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Prophylaxis of invasive aspergillosis in a high-risk patient, empiric antifungal therapy for febrile neutropenia in a high-risk patient, pulmonary aspergillosis, oropharyngeal candidiasis, mycosis due to Scedosporium prolificans |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | The patient will be using the requested drug orally or intravenously. |

| | |
|---|---|
| ***Prior Authorization Group*** | VOSEVI |
| ***Drug Names*** | VOSEVI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C) |
| ***Required Medical Information*** | For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Criteria will be applied consistent with current AASLD-IDSA guidance. |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | VOTRIENT |
| ***Drug Names*** | VOTRIENT |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma, ovarian cancer (epithelial ovarian, fallopian tube, or primary peritoneal). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma, AND 2) The patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, or e) extremity/superficial trunk, head/neck sarcoma. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | VRAYLAR |
| ***Drug Names*** | VRAYLAR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | XALKORI |
| ***Drug Names*** | XALKORI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent anaplastic lymphoma kinase (ALK)-positive or ROS1-positive non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification or MET exon 14 skipping mutation, ALK- or ROS1-postive brain metastases from NSCLC, ALK-positive inflammatory myofibroblastic tumors (IMT), ALK-positive anaplastic large cell lymphoma (ALCL). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | XELJANZ |
| ***Drug Names*** | XELJANZ, XELJANZ XR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For active psoriatic arthritis (new starts only): Patient meets BOTH of the following criteria: 1) Inadequate response to MTX or other nonbiologic DMARDs OR a prior biologic DMARD, AND 2) The requested drug is used in combination with a nonbiologic DMARD. For moderately to severely active ulcerative colitis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to at least one conventional therapy option (e.g., aminosalicylates), or 2) Inadequate response or intolerance to a prior biologic DMARD. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | XGEVA |
| ***Drug Names*** | XGEVA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Systemic mastocytosis related osteopenia or osteoporosis |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For hypercalcemia of malignancy, condition is refractory to intravenous (IV) bisphosphonate therapy or there is a clinical reason to avoid IV bisphosphonate therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

| | |
|---|---|
| ***Prior Authorization Group*** | XIFAXAN |
| ***Drug Names*** | XIFAXAN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being prescribed to reduce the risk of overt hepatic encephalopathy (HE) recurrence OR 2) The patient has the diagnosis of irritable bowel syndrome with diarrhea (IBS-D) AND 3) If the patient has previously received treatment with the requested drug, the patient has experienced a recurrence of symptoms AND 4) The patient has not already received an initial 14-day course of treatment and two additional 14-day courses of treatment with the requested drug OR 5) The patient has not previously received treatment with the requested drug |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Reduction in risk of overt HE recurrence: 6 Months, IBS-D: 14 Days |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | XOLAIR |
| ***Drug Names*** | XOLAIR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For allergic asthma initial therapy: 1) Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, and 3) Patient has inadequate asthma control despite current treatment with both of the following medications at optimized doses: a) Inhaled corticosteroid, and b) Additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For allergic asthma continuation therapy only: Patient's asthma control has improved on treatment with the requested drug since initiation of therapy. For chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), and 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks. For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy. |
| ***Age Restrictions*** | For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older. |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Allergic asthma: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year. |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | XOSPATA |
| ***Drug Names*** | XOSPATA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 18 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | XPOVIO |
| ***Drug Names*** | XPOVIO 100 MG ONCE WEEKLY, XPOVIO 60 MG ONCE WEEKLY, XPOVIO 80 MG ONCE WEEKLY, XPOVIO 80 MG TWICE WEEKLY |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | XTANDI |
| ***Drug Names*** | XTANDI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | XYREM |
| ***Drug Names*** | XYREM |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being prescribed for the treatment of excessive daytime sleepiness in a patient 7 years of age or older with narcolepsy and 2) If the patient is 18 years of age or older, the patient experienced an inadequate treatment response, intolerance, or contraindication to at least one central nervous system (CNS) wakefulness promoting drug and at least one central nervous system (CNS) stimulant drug OR 3) If the patient is less than 18 years of age, the patient experienced an inadequate treatment response, intolerance, or contraindication to at least one central nervous system (CNS) stimulant drug (NOTE: Examples of a central nervous system (CNS) stimulant drug are amphetamine, dextroamphetamine, or methylphenidate. Example of a central nervous system (CNS) wakefulness promoting drug is armodafinil. Coverage of armodafinil or amphetamines may require prior authorization). OR 4) The requested drug is being prescribed for the treatment of cataplexy in a patient 7 years of age or older with narcolepsy |
| ***Age Restrictions*** | 7 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy. |

| | |
|---|---|
| ***Prior Authorization Group*** | ZARXIO |
| ***Drug Names*** | ZARXIO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL), stem cell transplantation related indications, myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia, neutropenia related to renal transplant. |
| ***Exclusion Criteria*** | Use of the requested product within 24 hours prior to or following chemotherapy or radiotherapy. |
| ***Required Medical Information*** | For prophylaxis or treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ZEJULA |
| ***Drug Names*** | ZEJULA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Treatment is being started or was started no later than 8 weeks after the most recent platinum-based chemotherapy. |

| | |
|---|---|
| ***Prior Authorization Group*** | ZELBORAF |
| ***Drug Names*** | ZELBORAF |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Brain metastases with melanoma, non-small cell lung cancer, hairy cell leukemia, thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), rectal cancer, and colon cancer. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For brain metastases with melanoma, all of the following criteria must be met: 1) The tumor is positive for BRAF V600 activating mutation (e.g., BRAF V600E or V600K mutation), and 2) The requested drug will be used in combination with cobimetinib. For non-small cell lung cancer, tumor is positive for the BRAF V600E mutation. For thyroid carcinoma, tumor is positive for BRAF mutation. For rectal cancer, tumor is positive for the BRAF V600E mutation. For colon cancer, tumor is positive for the BRAF V600E mutation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ZOLINZA |
| ***Drug Names*** | ZOLINZA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Mycosis fungoides, Sezary syndrome. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ZYDELIG |
| ***Drug Names*** | ZYDELIG |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Relapsed or refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), refractory or progressive follicular lymphoma, and marginal zone lymphomas [nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma]. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ZYKADIA |
| ***Drug Names*** | ZYKADIA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Anaplastic lymphoma kinase (ALK)-positive inflammatory myofibroblastic tumor, recurrent ALK-positive non-small cell lung cancer (NSCLC), metastatic or recurrent ROS1-positive NSCLC, brain metastases from NSCLC. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For NSCLC, patient has recurrent or metastatic ALK-positive or ROS1-positive disease. For inflammatory myofibroblastic tumor, the tumor is ALK-positive. For brain metastases, patient has ALK-positive NSCLC. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ZYPREXA RELPREVV |
| ***Drug Names*** | ZYPREXA RELPREVV |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Tolerability with oral olanzapine has been established. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |