2025 Prior Authorization Criteria

ABIRATERONE

Affected Drugs

ABIRATERONE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Severe hepatic impairment (Child-Pugh Class C). NYHA Class III or IV heart failure. LVEF is less than 50%.

Required Medical Information

Abiraterone is administered in combination with Prednisone. AST and ALT less than or equal to 2.5X ULN and total bilirubin less than or equal to 1.5X ULN. Serum potassium is within normal limits prior to initiation of abiraterone.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Urologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ACITRETIN

Affected Drugs

ACITRETIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Females who are pregnant, or who intend to become pregnant during acitretin therapy or at any time for at least 3 years following discontinuation of acitretin therapy. Females who may not use reliable contraception while undergoing treatment with acitretin and for at least 3 years following discontinuation of treatment with acitretin. Patients with severely impaired liver or kidney function. Patients with chronic abnormally elevated blood lipid values. The combined use of acitretin and methotrexate. The combined use of acitretin and tetracyclines.

Required Medical Information

Females of reproductive potential must have had 2 negative urine or serum pregnancy tests with a sensitivity of at least 25 mIU/mL before receiving the initial acitretin prescription. Lipid Panel, Liver function tests: ALT, AST, LDH.

Age Restrictions

N/A

Prescriber Restrictions

Dermatologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one formulary topical corticosteroid (e.g., clobetasol propionate, fluocinonide, etc.) for the current condition is required prior to the initiation of acitretin.

ACTIMMUNE

Affected Drugs

ACTIMMUNE®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

In patients with chronic granulomatous disease (CGD), the member will be using Actimmune to reduce the frequency and severity of serious infections. In patients with severe malignant osteopetrosis (SMO), the member will be using Actimmune to delay time to disease progression.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ADEMPAS

Affected Drugs

ADEMPAS®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pregnancy in females of reproductive potential. The concurrent use of nitrates or nitric oxide donors (e.g., nitroglycerin, isosorbide mononitrate or dinitrate, amyl nitrite, etc.) or specific PDE-5 inhibitors (e.g., sildenafil, tadalafil, etc.) or nonspecific PDE inhibitors (e.g., dipyridamole, theophylline, etc.).

Required Medical Information

A diagnosis of 1) pulmonary arterial hypertension (PAH) (WHO Group 1) or 2) persistent or recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) after surgical treatment or inoperable CTEPH.

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist, Cardiologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

AIMOVIG

Affected Drugs

AIMOVIG®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one standard generic preventative antimigraine therapy (for example, beta blocker (e.g., propranolol, metoprolol, etc.) or antidepressant (e.g., venlafaxine, etc.), or anticonvulsant (e.g., topiramate, divalproex, etc.)) is required prior to initiation of Aimovig unless contraindicated or the member has had an inadequate response.

AKEEGA

Affected Drugs

AKEEGA™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Myelodysplastic Syndrome. Acute Myeloid Leukemia. Posterior Reversible Encephalopathy Syndrome. Concomitant use with strong CYP3A4 inducers (e.g., rifampin, etc.). Moderate or Severe Hepatic impairment.

Required Medical Information

Diagnosis of deleterious or suspected deleterious BRCA-mutated metastatic castration-resistant prostate cancer, used in combination with prednisone. Baseline CBC.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Urologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ALECENSA

Affected Drugs

ALECENSA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of (1) Anaplastic Lymphoma Kinase (ALK)-positive, metastatic Non-Small Cell Lung Cancer (NSCLC) as detected by an FDA-approved test (e.g., FoundationOne CDx, VENTANA ALK (D5F3) CDx Assay, etc.), or (2) ALK-positive NSCLC as detected by an FDA approved test (e.g., FoundationOne CDx, VENTANA ALK (D5F3) CDx Assay, etc.) in patients after tumor resection as adjuvant therapy (tumors greater than or equal to 4 cm or node positive). Baseline CPK levels and LFTs (ALT, AST, and total bilirubin).

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ALOSETRON

Affected Drugs

ALOSETRON

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with constipation. In patients with history of chronic or severe constipation or sequelae from constipation, intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions, ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state, Crohn's disease or ulcerative colitis, diverticulitis, severe hepatic impairment. Concomitant use of fluvoxamine.

Required Medical Information

Diagnosis of severe diarrhea-predominant chronic irritable bowel syndrome (presence of diarrhea and one or more of the following: frequent and severe abdominal pain/discomfort, frequent bowel urgency or fecal incontinence, or disability or restriction of daily activities due to IBS) in women with symptoms lasting for at least 6 months without anatomic or biochemical abnormalities of the gastrointestinal tract.

Age Restrictions

N/A

Prescriber Restrictions

Gastroenterologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of an antispasmodic (e.g., dicyclomine, etc.) or antidiarrheal agent (e.g., loperamide, etc.) is required for current condition prior to the initiation of alosetron.

ALUNBRIG

Affected Drugs

ALUNBRIG™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of Alunbrig with strong CYP3A inducers (e.g., rifampin, carbamazepine, phenytoin, etc.). Pregnancy in females of reproductive potential.

Required Medical Information

Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer as detected by an FDA-approved test. Baseline Creatine Phosphokinase (CPK) and pancreatic enzymes (e.g., lipase, amylase, etc.).

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

AMBRISENTAN

Affected Drugs

AMBRISENTAN

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pregnancy in females of reproductive potential. Idiopathic Pulmonary Fibrosis.

Required Medical Information

Diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1). Baseline hemoglobin.

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist, Cardiologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

AMITRIPTYLINE

Affected Drugs

AMITRIPTYLINE

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

A clinical justification indicating that the benefit of amitriptyline outweighs the potential risks will be required in members 65 years of age and older.

APOMORPHINE

Affected Drugs

APOMORPHINE HCL

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of 5HT3 antagonists, including antiemetics (e.g., ondansetron, granisetron, dolasetron, palonosetron, etc.) and alosetron.

Required Medical Information

Diagnosis of advanced Parkinson's disease. The member is experiencing breakthrough off periods related to their advanced Parkinson's disease while on current carbidopa/levodopa therapy.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

APREPITANT

Affected Drugs

APREPITANT

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved through the remainder of the contract year.

Other Criteria

The use of at least one of the following 5-HT3 antagonists is required prior to the initiation of aprepitant: 1) ondansetron for any FDA-approved indication or 2) granisetron for any FDA-approved indication, except for the prevention of postoperative nausea and vomiting. Part B coverage: 1) If aprepitant is used as full therapeutic replacement for IV anti-emetic drugs within 2 hours prior to administration of the anti-cancer treatment and will not exceed 48 hours after the treatment and 2) If aprepitant is used in combination with a 5-HT3 antagonist (e.g., ondansetron, granisetron, dolasetron, etc.) and dexamethasone and when patient is receiving one or more of the following anti-cancer agents: alemtuzumab, azacitidine, bendamustin, carboplatin, carmustine, cisplatin, clofarabine, cyclophosphamide, cytarabine, dacarbazine, daunorubicin, doxorubicin, epirubicin, idarubicin, ifosfamide, irinotecan, lomustine, mechlorethamine, oxaliplatin, streptozocin.

APTIOM

Affected Drugs

APTIOM®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Hypersensitivity to oxcarbazepine. Jaundice.

Required Medical Information

N/A

Age Restrictions

Approve if 4 years or older.

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one formulary anticonvulsant (e.g., valproic acid, topiramate, etc.) for the current condition is required prior to initiation of Aptiom.

ARCALYST

Affected Drugs

ARCALYST®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Arcalyst is not administered concurrently with any of the tumor necrosis factor (TNF) blockers (e.g., adalimumab, etanercept, etc.) or IL-1 inhibitors (e.g., ustekinumab, etc.).

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ARIKAYCE

Affected Drugs

ARIKAYCE®

Covered Uses

All FDA-approved Indications not otherwise excluded from Part D and some other medically accepted indications listed below under Off Label Uses field.

Off-label Uses

Treatment of cystic fibrosis pseudomonas aeruginosa infection

Exclusion Criteria

Non-refractory Mycobacterium avium complex (MAC) lung disease.

Required Medical Information

For treatment refractory Mycobacterium avium complex (MAC) lung disease: Initiation of Arikayce: 1) positive sputum culture for MAC within the past 3 months and after completion of a background multidrug regimen, and 2) the MAC isolate is susceptible to amikacin, and 3) Arikayce will be used in combination with a background multidrug regimen. Reauthorization: 1) Arikayce is prescribed in combination with a background multidrug regimen, and 2) either the patient has not achieved negative sputum cultures for MAC or the patient has achieved negative sputum cultures for MAC for less than 12 months. For cystic fibrosis pseudomonas aeruginosa infection, the patient has a positive culture of pseudomonas aeruginosa in the airway.

Age Restrictions

Approve if 18 years old or older.

Prescriber Restrictions

Infectious Disease Specialist, Pulmonologist

Coverage Duration

The PA will be approved for one year.

Other Criteria

N/A

ARMODAFINIL

Affected Drugs

ARMODAFINIL®

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of excessive sleepiness associated with 1) narcolepsy confirmed by a sleep study, 2) obstructive sleep apnea, or 3) shift work disorder or 4) bipolar disorder as an adjunct therapy

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

AUGTYRO

Affected Drugs

AUGTYRO™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Interstitial Lung Disease (ILD) or Pneumonitis. Concomitant use with strong and moderate CYP3A inhibitors (e.g., itraconazole, etc.), p-gp inhibitors (e.g., itraconazole, etc.), strong and moderate CYP3A inducers (e.g., rifampin, etc.).

Required Medical Information

Diagnosis of (1) locally advanced or metastatic ROS1-positive non-small cell lung cancer (NSCLC) or (2) solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion, are locally advanced or metastatic or where surgical resection is likely to result in severe morbidity, and have progressed following treatment or have no satisfactory alternative therapy. Baseline LFTs, serum CPK, serum uric acid levels

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Pulmonologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

AUSTEDO

Affected Drugs

AUSTEDO®
AUSTEDO® XR
AUSTEDO XR PATIENT TITRATION KIT

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Actively suicidal patients, or patients with untreated or inadequately treated depression. Impaired hepatic function. Concurrent use of monoamine oxidase inhibitors, reserpine or tetrabenazine.

Required Medical Information

Diagnosis of Huntington's disease chorea or tardive dyskinesia.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist, Psychiatrist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

AVONEX

Affected Drugs

AVONEX ®
AVONEX ADMINISTRATION PACK ®
AVONEX PEN ®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) relapsing forms of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and 2) active secondary progressive disease.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

AYVAKIT

Affected Drugs

AYVAKIT™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of Ayvakit with strong CYP3A inducers (e.g., rifampin, etc.) or moderate CYP3A inducers (e.g., efavirenz, etc.).

Required Medical Information

Diagnosis of 1) unresectable or metastatic gastrointestinal stromal tumor (GIST) harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations, or 2) advanced systemic mastocytosis, including aggressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm, or mast cell leukemia, or 3) indolent systemic mastocytosis.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist, Immunologist, Allergy Specialist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with advanced gastrointestinal stromal tumor (GIST), the use of at least 2 other kinase inhibitors (e.g., imatinib, sunitinib, Stivarga, Sprycel, Qinlock, etc.) is required prior to initiation of Ayvakit.

BALVERSA

Affected Drugs

BALVERSA ™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong CYP3A4 inducers (e.g., phenytoin, rifampin, carbamazepine, etc.).

Required Medical Information

Diagnosis of locally advanced or metastatic urothelial carcinoma with susceptible FGFR3 genetic alterations and disease has progressed on or after at least one line of prior systemic therapy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

BENLYSTA

Affected Drugs

BENLYSTA® 200MG/ML

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Severe active central nervous system lupus or progressive multifocal leukoencephalopathy (PML). Concomitant use with other biologic therapies.

Required Medical Information

Diagnosis of 1) active lupus nephritis or 2) active systemic lupus erythematosus (SLE), autoantibody-positive status is confirmed by laboratory testing.

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist, Nephrologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with SLE, the use of at least one standard therapy (e.g., prednisone, methylprednisolone, azathioprine, methotrexate, mycophenolate mofetil, chloroquine, hydroxychloroquine, etc.) is required. In patients with active lupus nephritis, the use of at least one standard therapy (e.g., prednisone, methylprednisolone, azathioprine, mycophenolate mofetil, etc.) is required.

BENZTROPINE

Affected Drugs

BENZTROPINE

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for one year.

Other Criteria

A clinical justification indicating that the benefit of benztropine outweighs the potential risks will be required in members 65 years of age and older.

B VS D - PART B VERSUS PART D COVERAGE PA

Affected Drugs

ABELCET®
ACETYLCYSTEINE SOLN
ACYCLOVIR SODIUM INJ
ALBUTEROL NEBULIZER
ALBUTEROL SULFATE
AMBISOME®
AMPHOTERICIN B INJ
AMPHOTERICIN B LIPOSOME
ARFORMOTEROL TARTRATE
ASTAGRAF XL®
AZASAN®
AZATHIOPRINE
BETHKIS®
BROVANA®
BUDESONIDE NEBULIZER
CALCITRIOL CAPS
CELLCEPT®
CINACALCET
CLINISOL SF®
CROMOLYN SODIUM
CYCLOPHOSPHAMIDE
CYCLOSPORINE
CYCLOSPORINE MODIFIED
DOXERCALCIFEROL
ENGERIX-B®
ENGERIX-B PEDIATRIC-ADOLESCENT®
ENVARSUS XR®
EVEROLIMUS (0.25MG, 0.5MG, 0.75MG TABS)
FORMOTEROL FUMARATE
GAMMAGARD LIQUID®
GAMUNEX-C®
GRANISETRON HCL TABS
HEPARIN SOLN
HEPARIN SOLN IN DEXTROSE
HEPLISAV-B®
IMURAN®
INTRALIPID
IPRATROPIUM BR

IPRATROPIUM-ALBUTEROL
JYNNEOS
KITABIS PAK
LEVALBUTEROL CONCENTRATE
LEVALBUTEROL HCL
LEVOCARNITINE INJ
LEVOCARNITINE SOLN
LEVOCARNITINE TABS
MEDROL®
METHYLPREDNISOLONE
MYCOPHENOLATE MOFETIL
MYCOPHENOLIC ACID
MYFORTIC®
MYHIBBIN
NEBUPENT®
NEORAL®
OHTUVAYRE™
ONDANSETRON ODT
ONDANSETRON HCL ORAL
ORAPRED®
PARICALCITOL
PENTAMIDINE ISETHIONATE
PERFOROMIST®
PLENAMINE™
PREDNISOLONE
PREDNISONE
PREDNISONE INTENSOL
PROGRAF®
PROSOL®
PULMICORT®
PULMOZYME®
RAPAMUNE®
RECOMBIVAX HB SUSP®
RECOMBIVAX HB SYR®
SANDIMMUNE®
SIROLIMUS
TACROLIMUS
TOBI SOLN®
TOBRAMYCIN NEBULIZER
TRAVASOL

YUPELRI ®

Covered Uses

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.

BESREMI

Affected Drugs

BESREMI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Existence of or history of a severe psychiatric disorder (e.g., severe depression, suicidal ideation or suicide attempt, etc.). Hepatic impairment (Child-Pugh B or C). History or presence of active serious or untreated autoimmune disease. Immunosuppressed transplant recipient. Severe or unstable cardiovascular disease (e.g., uncontrolled hypertension, congestive heart failure (greater than or equal to NYHA class 2), serious cardiac arrhythmia, significant coronary artery stenosis, unstable angina) or recent stroke or myocardial infarction.

Required Medical Information

A Diagnosis of Polycythemia Vera. Baseline CBC.

Age Restrictions

N/A

Prescriber Restrictions

Hematologist, Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

BETASERON

Affected Drugs

BETASERON®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) relapsing forms of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and 2) active secondary progressive disease.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

BEXAROTENE

Affected Drugs

BEXAROTENE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

In patients requesting oral bexarotene, Liver function tests: ALT/AST, Fasting lipid panel, WBC, thyroid function tests.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist or Dermatologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The patient was prescribed at least one systemic or topical therapy for the current condition prior to the initiation of bexarotene.

BOSENTAN

Affected Drugs

BOSENTAN

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pregnancy in females of reproductive potential.

Required Medical Information

Diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1) in patients with NYHA Functional Class II-IV symptoms. Baseline LFTs (ALT, AST, bilirubin).

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist, Cardiologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The prior use of sildenafil citrate is required for the current condition in adult patients initiating bosentan.

BOSULIF

Affected Drugs

BOSULIF®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Bosulif will be used in patients with 1) newly-diagnosed or resistant or intolerant to prior therapy chronic phase Ph+ chronic myelogenous leukemia (CML) or 2) accelerated, or blast phase Philadelphia chromosome positive chronic myelogenous leukemia (Ph+ CML) with resistance or intolerance to prior therapy (e.g. imatinib, dasatinib, or nilotinib, etc.). Baseline CBC and LFTs prior to initiation of Bosulif.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

BRAFTOVI

Affected Drugs

BRAFTOVI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of Braftovi with strong or moderate CYP3A inducers (e.g., rifampin, carbamazepine, phenytoin, etc.).

Required Medical Information

Diagnosis of 1) unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test (e.g., THXID BRAF Kit, etc.), in combination with binimetinib or 2) metastatic colorectal cancer (CRC) with a BRAF V600E mutation, as detected by an FDA-approved test (e.g., Qiagen therascreen BRAF V600E RGQ PCR Kit, etc.) after prior therapy (e.g., irinotecan, etc.), in combination with cetuximab or 3) metastatic colorectal cancer (CRC) with a BRAF V600E mutation, as detected by an FDA-approved test (e.g., Qiagen therascreen BRAF V600E RGQ PCR Kit, etc.), in combination with cetuximab and mFOLFOX6 or 4) metastatic non-small cell lung cancer with a BRAF V600E mutation, as detected by an FDA-approved test, in combination with binimetinib. Baseline serum electrolytes (e.g., potassium, magnesium, etc.).

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist, Gastroenterologist, Pulmonologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with unresectable or metastatic melanoma with BRAF V600E mutation, the use of Zelboraf or Tafinlar is required prior to the initiation of Braftovi. In patients with unresectable or metastatic melanoma with BRAF V600K mutation or metastatic

NSCLC with a BRAF V600E mutation, the use of Tafinlar is required prior to the initiation of Braftovi

BRIVIACT

Affected Drugs

BRIVIACT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if 1 month of age or older.

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one formulary anticonvulsant (e.g., valproic acid, topiramate, etc.) for the current condition is required prior to initiation of Briviact.

BRUKINSA

Affected Drugs

BRUKINSA™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) mantle cell lymphoma (MCL) in patients who have received at least one prior therapy or 2) Waldenstrom's macroglobulinemia or 3) relapsed or refractory marginal zone lymphoma (MZL) in adult patients who have received at least one anti-CD20-based regimen or 4) chronic lymphocytic leukemia (CLL) or 5) small lymphocytic lymphoma (SLL) or 6) relapsed or refractory follicular lymphoma (FL) in adult patients after receiving at least two lines of systemic therapy (Brukinsa will be used in combination with obinutuzumab). Baseline CBC.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

BUDESONIDE

Affected Drugs

BUDESONIDE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of prednisone (or oral prednisolone) is required for current condition prior to the initiation of Budesonide.

BUDESONIDE ER

Affected Drugs

BUDESONIDE ER

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of 1) an aminosalicylate and 2) prednisone (or oral prednisolone) is required for current condition prior to the initiation of Budesonide.

CABOMETYX

Affected Drugs

CABOMETYX™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Recent history of hemorrhage or hemoptysis. Severe hepatic impairment. Severe uncontrolled hypertension.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In renal cell carcinoma, hepatocellular carcinoma, and adults with differentiated thyroid cancer, the use of Lenvima or sorafenib is required prior to the initiation of Cabometyx. In patients with previously treated, unresectable, locally advanced or metastatic pancreatic neuroendocrine tumors (pNET), or in patients with previously treated, unresectable, locally advanced or metastatic extra-pancreatic neuroendocrine tumors (epNET), or in pediatric patients with differentiated thyroid cancer, the use of a pre-requisite drug is not required prior to the initiation of Cabometyx.

CALQUENCE

Affected Drugs

CALQUENCE™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) mantle cell lymphoma who have received at least one prior therapy (e.g., CHOP, cytarabine-based, etc.) or 2) chronic lymphocytic leukemia (CLL) or 3) small lymphocytic lymphoma (SLL) or 4) previously untreated mantle cell lymphoma that is ineligible for autologous hematopoietic stem cell transplantation (HSCT), used in combination with bendamustine and rituximab. Baseline CBC.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

CAPLYTA

Affected Drugs

CAPLYTA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Neuroleptic malignant syndrome. Concomitant use with CYP3A4 inducers (e.g., rifampin, etc.).

Required Medical Information

Diagnosis of 1) schizophrenia or 2) depressive episodes associated with bipolar I or II disorder (bipolar depression). Baseline CBC, heart rate and blood pressure.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with schizophrenia, the use of at least 2 other atypical antipsychotics (e.g., asenapine, aripiprazole, paliperidone, olanzapine, quetiapine, risperidone, ziprasidone, etc.) is required prior to initiation of Caplyta. In patients with depressive episodes associated with bipolar I or II disorder, Caplyta will be used as monotherapy or as adjunctive therapy with lithium or valproate.

CAPRELSA

Affected Drugs

CAPRELSA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Congenital long QT syndrome or QTcF interval greater than 450 ms or history of Torsades de pointes. Caprelsa is concurrently administered with anti-arrhythmic drugs (e.g., amiodarone, disopyramide, procainamide, sotalol, dofetilide, etc.) and other drugs that may prolong the QT interval (e.g., chloroquine, clarithromycin, dolasetron, granisetron, haloperidol, methadone, moxifloxacin, pimozide, etc.)

Required Medical Information

Baseline ECG. The patient's baseline calcium, potassium and magnesium levels are within normal limits.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Endocrinologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

CARGLUMIC ACID

Affected Drugs

CARGLUMIC ACID®

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency, or propionic acidemia (PA), or methylmalonic acidemia (MMA).

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

CAYSTON

Affected Drugs

CAYSTON®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of cystic fibrosis (CF). Pseudomonas Aeruginosa lung infection confirmed by positive culture.

Age Restrictions

Approve if 7 years old or older.

Prescriber Restrictions

Pulmonologist, Infectious Disease Specialist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

CERDELGA

Affected Drugs

CERDELGA™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Extensive metabolizers (EMs) or intermediate metabolizers (IMs) taking a strong or moderate CYP2D6 inhibitor (e.g., paroxetine, terbinafine, etc.) concomitantly with a strong or moderate CYP3A inhibitor (e.g., ketoconazole, fluconazole, etc.). IMs or poor metabolizers (PMs) taking a strong CYP3A inhibitor (e.g., ketoconazole, etc.). Pre-existing cardiac disease (e.g., congestive heart failure, recent acute myocardial infarction, bradycardia, heart block, ventricular arrhythmia, etc.) or long QT syndrome or concomitant use of Class IA (e.g., quinidine, procainamide, etc.) or Class III (e.g., amiodarone, sotalol, etc.) antiarrhythmic medications.

Required Medical Information

Diagnosis of Gaucher disease type 1 (GD1) confirmed by laboratory or genetic testing. Member is a CYP2D6 extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM) as detected by an FDA-approved genotyping test.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

CHLORPROMAZINE

Affected Drugs

CHLORPROMAZINE

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

A clinical justification indicating that the benefit of chlorpromazine outweighs the potential risks will be required in members 65 years of age and older.

CINRYZE

Affected Drugs

CINRYZE®

Covered Uses

All FDA-approved indications.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of hereditary angioedema (HAE) requiring routine prophylaxis against angioedema attacks in adults, adolescents and pediatric patients.

Age Restrictions

Approve if 6 years or older.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

CLOBAZAM

Affected Drugs

CLOBAZAM

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

A clinical justification indicating that the benefit of clobazam outweighs the potential risks will be required in members 65 years of age and older.

CLOMIPRAMINE

Affected Drugs

CLOMIPRAMINE

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

Initial: 3 months. Reauthorization: Lifetime.

Other Criteria

A clinical justification indicating that the benefit of clomipramine outweighs the potential risks will be required in members 65 years of age and older.

COMETRIQ

Affected Drugs

COMETRIQ®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with recent history of hemorrhage or hemoptysis. In patients with severe uncontrolled hypertension.

Required Medical Information

Oral examination prior to initiation of Cometriq.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

COPAXONE

Affected Drugs

COPAXONE®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) relapsing forms of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and 2) active secondary progressive disease.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

COPIKTRA

Affected Drugs

COPIKTRA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong CYP3A4 inducers (e.g., phenytoin, rifampin, carbamazepine, etc.)

Required Medical Information

Diagnosis of Relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) after at least two prior therapies (e.g., ibrutinib, venetoclax, etc.)

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

CORLANOR

Affected Drugs

CORLANOR®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Acute decompensated heart failure. Clinically significant hypotension. Sink sinus syndrome, sinoatrial block or 3rd degree AV block, unless a functioning demand pacemaker is present. Clinically significant bradycardia. Severe hepatic impairment. Heart rate maintained exclusively by the pacemaker. In combination with strong CYP3A4 inhibitors (e.g., itraconazole, clarithromycin, nelfinavir, nefazodone, etc.).

Required Medical Information

Corlanor will be used (1) to reduce the risk of hospitalization for worsening heart failure in adults with stable, symptomatic chronic heart failure (CHF) with left ventricular ejection fraction 35% or less, who are in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute or (2) for the treatment of stable symptomatic heart failure due to dilated cardiomyopathy (DCM) in pediatric patients aged 6 months and older, who are in sinus rhythm with an elevated heart rate.

Age Restrictions

N/A

Prescriber Restrictions

Cardiologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In adults with CHF, patient has NYHA Class II, III, or IV symptoms and is currently receiving maximally tolerated doses of beta-blockers unless contraindicated.

COSENTYX

Affected Drugs

COSENTYX®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with biologic DMARDs (e.g., TNF Antagonists)

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist, Dermatologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with Ankylosing Spondylitis or Non-radiographic Axial Spondyloarthritis or Enthesitis-Related Arthritis, the use of at least 1 NSAID is required for the current condition prior to the initiation of Cosentyx. In patients with plaque psoriasis, the use of at least one systemic therapy (e.g., methotrexate, cyclosporine, acitretin, etc.) is required prior to the initiation of Cosentyx if a patient is a candidate for systemic therapy. For the indications listed above, the use of at least one prerequisite drug is not required in patients who have already tried a biologic. In patients with Psoriatic Arthritis or Hidradenitis Suppurativa, the use of a pre-requisite drug is not required prior to the initiation of Cosentyx.

COTELLIC

Affected Drugs

COTELLIC ™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong or moderate CYP3A inducers (e.g., carbamazepine, efavirenz, phenytoin, rifampin, etc.).

Required Medical Information

In patients with 1) unresectable or metastatic melanoma with a BRAF V600E or V600K mutation as detected by an FDA-approved test, cotellic is used in combination with Zelboraf (vemurafenib) or 2) histiocytic neoplasms, cotellic is used as a single agent. Baseline LFTs, serum CPK, creatinine levels, and ophthalmic evaluation. Baseline LVEF is greater than 50% confirmed by appropriate methodology (e.g., Echocardiogram, MUGA, MRI, etc.).

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

CYCLOBENZAPRINE

Affected Drugs

CYCLOBENZAPRINE

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for 3 months.

Other Criteria

A clinical justification indicating that the benefit of cyclobenzaprine outweighs the potential risks will be required in members 65 years of age and older.

DALFAMPRIDINE

Affected Drugs

DALFAMPRIDINE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

History of seizures. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/min).

Required Medical Information

Initiation of dalfampridine: 1) Diagnosis of multiple sclerosis, and 2) confirmation that patient has difficulty walking (e.g., patient has completed a timed 25-foot walk test, etc.). Reauthorization: confirmation that the patient's walking improved with dalfampridine therapy.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

Initial: 3 months. Reauthorization: 12 months.

Other Criteria

N/A

DANZITEN

Affected Drugs

DANZITEN

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Hypokalemia. Hypomagnesemia. Long QT syndrome. Concomitant use with proton pump inhibitors (e.g., omeprazole, pantoprazole, etc.). Concomitant use with strong CYP3A inducers (e.g., rifampicin, etc.).

Required Medical Information

1) Newly diagnosed Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase or 2) a diagnosis of chronic phase (CP) and accelerated phase (AP) Ph+ CML resistant to prior therapy that included imatinib or patient was intolerant to prior therapy that included imatinib.

Age Restrictions

N/A

Prescriber Restrictions

Hematologist, Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

DASATINIB

Affected Drugs

DASATINIB

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Dasatinib will be used in patients with 1) newly diagnosed Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase, 2) chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy including imatinib, or 3) Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) with resistance or intolerance to prior therapy (e.g. imatinib, etc.). In pediatric patients with Ph+ CML in chronic phase or newly diagnosed Ph+ ALL in combination with chemotherapy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

DAURISMO

Affected Drugs

DAURISMO

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of acute myeloid leukemia (AML) in adult patients who are 75 years old or older or adult patients who have comorbidities that preclude use of intensive induction chemotherapy. Used in combination with low-dose cytarabine.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

DEFERASIROX

Affected Drugs

DEFERASIROX

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Platelet count less than 50 x 10(9)/L. Patient with high-risk myelodysplastic syndromes (MDS), advanced malignancies, serum creatinine greater than 2 times the age-appropriate upper limit of normal, creatinine clearance less than 40 mL/min, or severe (Child-Pugh C) hepatic impairment.

Required Medical Information

Baseline serum ferritin and liver function tests (ALT, AST, bilirubin).

Age Restrictions

N/A

Prescriber Restrictions

Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

DEFERIPRONE

Affected Drugs

DEFERIPRONE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of transfusional iron overload due to thalassemia syndromes, sickle cell disease, or other anemias. Baseline absolute neutrophil count (ANC).

Age Restrictions

N/A

Prescriber Restrictions

Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

DESIPRAMINE

Affected Drugs

DESIPRAMINE

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

A clinical justification indicating that the benefit of desipramine outweighs the potential risks will be required in members 65 years of age and older.

DIABETIC SUPPLIES

Affected Drugs

DIABETIC SUPPLIES

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for one year.

Other Criteria

Approve if the medical supply is being requested for a use that is directly associated with delivering insulin to the body

DIACOMIT

Affected Drugs

DIACOMIT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of seizures associated with Dravet syndrome while on current clobazam therapy.

Age Restrictions

Approve if 6 months of age or older.

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one formulary anticonvulsant (e.g., valproic acid, topiramate, etc.) for the current condition is required prior to initiation of Diacomit.

DIAZEPAM

Affected Drugs

DIAZEPAM

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

A clinical justification indicating that the benefit of diazepam outweighs the potential risks will be required in members 65 years of age and older.

DICLOFENAC SODIUM 3% GEL

Affected Drugs

DICLOFENAC SODIUM 3% GEL

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of actinic keratosis. Reauthorization: positive clinical response to diclofenac sodium 3% gel therapy.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of topical fluorouracil or imiquimod is required prior to the initiation of diclofenac sodium 3% gel.

DICYCLOMINE

Affected Drugs

DICYCLOMINE

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for one year.

Other Criteria

A clinical justification indicating that the benefit of dicyclomine outweighs the potential risks will be required in members 65 years of age and older.

DIHYDROERGOTAMINE

Affected Drugs

DIHYDROERGOTAMINE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

For the treatment of migraine, the use of at least one generic triptan therapy (e.g., sumatriptan, zolmitriptan, naratriptan, rizatriptan, etc.) is required prior to initiation of dihydroergotamine mesylate unless contraindicated or the member has had an inadequate response to triptan therapy.

DIMETHYL FUMARATE

Affected Drugs

DIMETHYL FUMARATE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of relapsing forms of multiple sclerosis to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. Recent (e.g., within six months) complete blood count (CBC).

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

DOXEPIN

Affected Drugs

DOXEPIN

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

For the treatment of anxiety and/or depression, the average daily dose of doxepin that is greater than 6 mg will require a clinical justification indicating that the benefit of doxepin outweighs the potential risks will be required in members 65 years of age and older.

DRONABINOL

Affected Drugs

DRONABINOL

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

In patients with AIDS, diagnosis of anorexia with weight loss.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

CINV: 6 months. AIDS Anorexia: the PA will be approved through the remainder of the contract year.

Other Criteria

For the treatment of nausea and vomiting associated with cancer chemotherapy, the use of at least one of the following agents is required prior to the initiation of dronabinol: ondansetron, granisetron (or granisol), aprepitant, metoclopramide. Part B coverage: 1) if dronabinol is used as full therapeutic replacement for IV anti-emetic drugs within 2 hours prior to administration of the anti-cancer treatment and will not exceed 48 hours after the treatment. Part D coverage if used after 48 hours of administration of chemotherapy.

DROXIDOPA

Affected Drugs

DROXIDOPA

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Initiation of therapy: a diagnosis of symptomatic neurogenic orthostatic hypotension (NOH) caused by primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, pure autonomic failure, etc.), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy. Reauthorization: a positive clinical response to therapy (e.g., improvement in dizziness, lightheadedness, etc.).

Age Restrictions

Approve if 18 years old or older.

Prescriber Restrictions

Cardiologist, Neurologist

Coverage Duration

Initiation: 1 month. Reauthorization: Lifetime.

Other Criteria

The use of midodrine or fludrocortisone is required prior to the initiation of droxidopa.

DUPIXENT

Affected Drugs

DUPIXENT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concurrent use with Xolair or another Anti-Interleukin (IL) Monoclonal Antibody.

Required Medical Information

Diagnosis of 1) moderate-to-severe atopic dermatitis whose disease is not adequately controlled or 2) moderate-to-severe asthma characterized by an eosinophilic phenotype or oral corticosteroid dependent asthma, as add-on maintenance treatment. Baseline blood eosinophil level greater than or equal to 150 cells per microliter or 3) chronic rhinosinusitis with nasal polyposis as add-on maintenance treatment or 4) eosinophilic esophagitis (EoE) in patients weighing at least 15kg or 5) prurigo nodularis or 6) inadequately controlled chronic obstructive pulmonary disease (COPD) with an eosinophilic phenotype (i.e., blood eosinophil at least 300 cells per microliter) as add-on maintenance treatment or 7) chronic spontaneous urticaria (CSU) that remains symptomatic despite H1 antihistamine treatment or 8) bullous pemphigoid.

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist, Dermatologist, Immunologist, Allergy Specialist, Gastroenterologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with refractory, moderate to severe atopic dermatitis, the use of at least one medium or high potency topical corticosteroid (e.g., fluocinonide, etc.) or one topical calcineurin inhibitor (e.g., tacrolimus) is required (unless contraindicated or unable to tolerate) prior to initiation of Dupixent. In patients with moderate-to-severe eosinophilic asthma, the patient has been unable to achieve adequate asthma control while on

inhaled corticosteroid therapy (unless contraindicated or unable to tolerate). In patients with chronic rhinosinusitis with nasal polyposis, the patient is not adequately controlled on at least one formulary nasal corticosteroid (e.g., mometasone, etc.) unless contraindicated or unable to tolerate. In patients with EoE, the use of at least one proton pump inhibitor (e.g., omeprazole, lansoprazole, pantoprazole, etc.) is required (unless unable to tolerate) prior to initiation of Dupixent. In patients with prurigo nodularis or in patients with bullous pemphigoid, the use of at least one prerequisite drug is not required prior to initiation of Dupixent. In patients with COPD, the patient is not adequately controlled on at least two of any of the following: long-acting muscarinic antagonists (LAMA), long-acting beta agonists (LABA) or inhaled corticosteroid therapy (unless contraindicated or unable to tolerate) or has a history of at least two moderate or one severe COPD exacerbations in the previous 12 months.

ELIGARD

Affected Drugs

ELIGARD®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In women who are or may become pregnant.

Required Medical Information

Diagnosis of advanced prostate cancer. Baseline electrolytes (e.g., potassium, magnesium, etc.), serum testosterone, PSA, and ECG.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

EMGALITY

Affected Drugs

EMGALITY®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

For the preventive treatment of migraine, use of at least one standard generic preventative antimigraine therapy (for example, beta blocker (e.g., propranolol, metoprolol, etc.) or antidepressant (e.g., venlafaxine, etc.), or anticonvulsant (e.g., topiramate, divalproex, etc.)) is required prior to initiation of Emgality unless contraindicated or the member has had an inadequate response. For the treatment of episodic cluster headache, the use of at least one prerequisite drug is not required.

ENBREL

Affected Drugs

ENBREL®
ENBREL MINI®
ENBREL SURECLICK®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with biologic DMARDs (e.g., TNF Antagonists)

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist, Dermatologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with Rheumatoid Arthritis or Polyarticular-Course Juvenile Rheumatoid Arthritis, the use of at least one conventional Disease-Modifying Anti-Rheumatic Drug (e.g., methotrexate, sulfasalazine, etc.) is required for the current condition prior to the initiation of Enbrel. In patients with Ankylosing Spondylitis, the use of at least 1 NSAID is required for the current condition prior to the initiation of Enbrel. In patients with plaque psoriasis, the use of at least one systemic therapy (e.g., methotrexate, cyclosporine, acitretin, etc.) is required prior to the initiation of Enbrel if a patient is a candidate for systemic therapy. For the indications listed above, the use of at least one prerequisite drug is not required in patients who have already tried a biologic. In patients with Psoriatic Arthritis, the use of a pre-requisite drug is not required prior to the initiation of Enbrel.

ENDARI

Affected Drugs

ENDARI™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of acute complications of sickle cell disease.

Age Restrictions

Approve if 5 years old or older

Prescriber Restrictions

Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

EPCLUSA

Affected Drugs

EPCLUSA®

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of Epclusa with P-gp inducers or moderate to potent CYP inducers (e.g., rifampin, St. John's wort, carbamazepine, etc.).

Required Medical Information

Diagnosis of chronic hepatitis C virus (HCV) genotypes 1a, 1b, 2, 3, 4, 5, or 6 infection confirmed via detectable serum hepatitis C virus RNA by quantitative assay. Criteria will be applied consistent with current AASLD IDSA guidance.

Age Restrictions

N/A

Prescriber Restrictions

Infectious Disease Specialist, Gastroenterologist, Hepatologist

Coverage Duration

The PA will be approved consistent with current AASLD IDSA guidance.

Other Criteria

Criteria will be applied consistent with current AASLD IDSA guidance.

EPIDIOLEX

Affected Drugs

EPIDIOLEX®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of seizures associated with 1) Dravet syndrome or 2) Lennox-Gastaut syndrome or 3) tuberous sclerosis complex. Baseline liver enzymes (e.g., transaminases, etc.) and bilirubin.

Age Restrictions

Approve if 1 year old or older

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one formulary anticonvulsant (e.g., valproic acid, topiramate, lamotrigine, etc.) is required prior to initiation of Epidiolex.

ERIVEDGE

Affected Drugs

ERIVEDGE®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

A confirmed negative pregnancy test for women of childbearing age prior to initiation of therapy. Diagnosis of metastatic Basal Cell Carcinoma (BCC) or locally advanced BCC. In a patient with locally advanced BCC, BCC recurrence following surgery or radiation is required if a patient is a candidate for surgery or radiation.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Dermatologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ERLEADA

Affected Drugs

ERLEADA™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pregnancy in females of reproductive potential. History of seizures.

Required Medical Information

Diagnosis of non-metastatic castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer. Concurrent use of Erleada with a gonadotropin-releasing hormone (GnRH) analog unless the patient has had a bilateral orchiectomy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Urologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ERLOTINIB

Affected Drugs

ERLOTINIB

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Covered Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or 2) locally advanced, unresectable, or metastatic pancreactic cancer. In patients with pancreatic cancer, erlotinib will be used in combination with gemcitabine. Baseline serum electrolytes (e.g., potassium, magnesium, etc.), renal function test (e.g., SCr, BUN, etc), and LFTs (e.g., ALT, AST, etc.).

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ESLICARBAZEPINE

Affected Drugs

ESLICARBAZEPINE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Hypersensitivity to oxcarbazepine. Jaundice.

Required Medical Information

N/A

Age Restrictions

Approve if 4 years or older.

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one formulary anticonvulsant (e.g., valproic acid, topiramate, etc.) for the current condition is required prior to initiation of eslicarbazepine.

EULEXIN

Affected Drugs

EULEXIN™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Severe hepatic impairment.

Required Medical Information

Diagnosis of locally confined Stage B2-C and Stage D2 metastatic carcinoma of the prostate. Eulexin will be used in combination with LHRH-agonists (e.g., leuprolide , etc.). Baseline LFTs

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Urologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

EVEROLIMUS

Affected Drugs

EVEROLIMUS (2.5MG, 5MG, 7.5MG, 10MG TABS)

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Co-administered with P-gp and strong CYP3A4 inhibitors, such as ketoconazole.

Required Medical Information

In patients with renal angiomyolipoma and tuberous sclerosis complex (TSC), no immediate surgery is required. In patients with progressive neuroendocrine tumors (PNET) of pancreatic origin and progressive, well-differentiated, non-functional neuroendocrine tumors (NET) of gastrointestinal or lung origin, absence of functional carcinoid tumors and disease is unresectable, locally advanced or metastatic. In patients with tuberous sclerosis complex (TSC) who have subependymal giant cell astrocytoma (SEGA) and require therapeutic intervention, disease is unresectable. CBC, SrCr, BUN, serum glucose, lipid panel.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

For the treatment of advanced renal cell carcinoma, the use of sunitinib or sorafenib or both is required prior to the initiation of everolimus. For the treatment of advanced hormone receptor-positive, HER2-negative breast cancer in postmenopausal women, everolimus will be used in combination with exemastane after failure of treatment with letrozole or anastrozole.

EVEROLIMUS SOLUBLE TABLET

Affected Drugs

EVEROLIMUS (2MG, 3MG, 5MG TABS FOR SUSP)

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Everolimus soluble tablet is co-administered with strong inhibitors of CYP3A4 (e.g., ketoconazole, itraconazole, etc.).

Required Medical Information

CBC, SrCr, BUN, serum glucose, lipid panel.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

FANAPT

Affected Drugs

FANAPT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Severe hepatic impairment (Child-Pugh C).

Required Medical Information

Diagnosis of 1) schizophrenia or 2) manic or mixed episodes associated with bipolar I disorder. Baseline electrolytes, heart rate, blood pressure.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In manic or mixed episodes associated with bipolar I disorder, Fanapt will be used for acute treatment.

FASENRA

Affected Drugs

FASENRA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concurrent use with Xolair or another Anti-Interleukin (IL) Monoclonal Antibody. Being used as a single agent.

Required Medical Information

Diagnosis of 1) severe asthma with an eosinophilic phenotype or 2) eosinophilic granulomatosis with polyangiitis. Baseline blood eosinophil level greater than or equal to 150 cells per microliter.

Age Restrictions

6 years or older

Prescriber Restrictions

Pulmonologist, Immunologist, Allergy Specialist, Rheumatologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with asthma, the member has been unable to achieve adequate asthma control while on maximum tolerated inhaled corticosteroid therapy in combination with a long acting beta agonist unless contraindicated. For current Fasenra users, the member is stable on therapy and will continue on asthma controller inhalers.

FINGOLIMOD

Affected Drugs

FINGOLIMOD

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with a recent (i.e., within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Baseline QTc interval greater than or equal to 500 ms. Treatment with Class Ia or Class III anti-arrhythmic drugs (e.g., quinidine, procainamide, disopyramide, sotalol, amiodarone, etc.). In patients with active or chronic infection (e.g., pneumonia, disseminated primary herpes zoster, herpes simplex encephalitis, etc.).

Required Medical Information

Diagnosis of relapsing forms of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease. Baseline ECG, recent CBC (i.e., within the last 6 months), recent (i.e., within the last 6 months) liver enzymes: transaminase and bilirubin levels, and an ophthalmologic evaluation prior to initiation of fingolimod.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

FINTEPLA

Affected Drugs

FINTEPLA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of seizures associated with Dravet syndrome or Lennox-Gastaut syndrome.

Age Restrictions

Approve if 2 years old or older.

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one formulary anticonvulsant (e.g., valproic acid, topiramate, etc.) for the current condition is required prior to initiation of Fintepla.

FOTIVDA

Affected Drugs

FOTIVDA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of strong CYP3A inducers (e.g., rifampin, etc.). Severe arterial thromboembolic event (e.g., myocardial infarction, stroke, etc.). Severe hemorrhagic event.

Required Medical Information

Diagnosis of relapsed or refractory advanced renal cell carcinoma (RCC) following at least two prior systemic therapies (e.g., Inlyta, Cabometyx, sunitinib, pazopanib, sorafenib, Lenvima, etc.).

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

FRUZAQLA

Affected Drugs

FRUZAQLA™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Gastrointestinal perforation or fistula. Posterior Reversible Encephalopathy Syndrome. Arterial thromboembolism. Concomitant use with strong CYP3A inducers (e.g., rifampin, etc.).

Required Medical Information

Diagnosis of metastatic colorectal cancer previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if RAS wild-type and medically appropriate, an anti-EGFR therapy. Baseline LFTs, urine protein.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Gastroenterologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

FYCOMPA

Affected Drugs

FYCOMPA™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Severe hepatic impairment (Child-Pugh C). Severe renal impairment. Patients undergoing hemodialysis.

Required Medical Information

N/A

Age Restrictions

Partial-onset seizures: 4 years or older. Primary generalized tonic-clonic seizures: 12 years or older.

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one formulary anticonvulsant (e.g., valproic acid, topiramate, etc.) for the current condition is required prior to initiation of Fycompa.

GAVRETO

Affected Drugs

GAVRETO™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) metastatic rearranged during transfection (RET) fusion-positive non-small cell lung cancer (NSCLC) as detected by an FDA approved test or 2) advanced or metastatic RET fusion-positive thyroid cancer that requires systemic therapy and is radioactive iodine-refractory (if radioactive iodine is appropriate). Baseline ALT, AST.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

GEFITINIB

Affected Drugs

GEFITINIB

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of metastatic non-small cell lung cancer (NSCLC) with EGFR exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

GENOTROPIN

Affected Drugs

GENOTROPIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with Acute Critical Illness due to complications following open heart surgery, abdominal surgery or multiple accidental trauma, or those with acute respiratory failure. In children with Prader-Willi syndrome who are severely obese or have severe respiratory impairment. In patients with Active Malignancy. In Patients with Active Proliferative or Severe Non-Proliferative Diabetic Retinopathy. In children with closed epiphyses.

Required Medical Information

Diagnoses of Prader-Willi syndrome and Turner Syndrome are confirmed by genetic testing. Idiopathic short stature is confirmed by height less or equal to 2.25 SD (standard deviation) below the mean height for age and the diagnostic evaluation excludes other causes of short stature that should be treated by other means. Diagnosis of growth failture due to inadequate secretion of endogenous growth hormone. Diagnosis of short stature born small for gestational age with no catch-up growth by 2 years of age. In adults with Growth Hormone Deficiency, IGF-1 level of less than 84 ng/ml or Growth hormone stimulation tests, e.g., insulin tolerance test (ITT) with GH level of less than 5 mcg/L, GHRH with arginine with GH level of less than 4.1 mcg/L.

Age Restrictions

N/A

Prescriber Restrictions

Endocrinologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

GILOTRIF

Affected Drugs

GILOTRIF®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

A Diagnosis of 1) metastatic non-small cell lung cancer (NSCLC) with EGFR exon 19 deletions, exon 21 (L858R), L861Q, G719X or S768I substitution mutations as detected by an FDA-approved test (e.g., the therascreen EGFR RGQ PCR Kit, etc.) OR 2) metastatic, squamous NSCLC that has progressed after platinum-based chemotherapy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

GLATIRAMER

Affected Drugs

GLATIRAMER

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) relapsing forms of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and 2) active secondary progressive disease.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

GLATOPA

Affected Drugs

GLATOPA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) relapsing forms of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and 2) active secondary progressive disease.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

GLUCAGON-LIKE PEPTIDE-1 AGONISTS

Affected Drugs

GLUCAGON-LIKE PEPTIDE-1 AGONISTS

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Type 2 diabetes mellitus diagnosis

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for one year.

Other Criteria

N/A

GLUTAMINE

Affected Drugs

GLUTAMINE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Glutamine will be used in patients to reduce the acute complications of sickle cell disease.

Age Restrictions

Approve if 5 years old or older

Prescriber Restrictions

Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

GOMEKLI

Affected Drugs

GOMEKLI™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of neurofibromatosis type 1 with symptomatic plexiform neurofibromas not amenable to complete resection

Age Restrictions

Approve if 2 years old and older.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved through the remainder of the contract year.

Other Criteria

N/A

HARVONI

Affected Drugs

HARVONI®

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of hepatitis C infection confirmed via detectable serum hepatitis C virus RNA by quantitative assay. Criteria will be applied consistent with current AASLD IDSA guidance.

Age Restrictions

N/A

Prescriber Restrictions

Infectious Disease Specialist, Gastroenterologist, Hepatologist

Coverage Duration

The PA will be approved consistent with current AASLD IDSA guidance.

Other Criteria

Criteria will be applied consistent with current AASLD IDSA guidance.

HUMATROPE

Affected Drugs

HUMATROPE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with Acute Critical Illness due to complications following open heart surgery, abdominal surgery or multiple accidental trauma, or those with acute respiratory failure. In children with Prader-Willi syndrome who are severely obese or have severe respiratory impairment. In patients with Active Malignancy. In Patients with Active Proliferative or Severe Non-Proliferative Diabetic Retinopathy. In children with closed epiphyses.

Required Medical Information

Diagnoses of Turner Syndrome or SHOX deficiency are confirmed by genetic testing. Idiopathic short stature is confirmed by height less or equal to 2.25 SD (standard deviation) below the mean height for age and the diagnostic evaluation excludes other causes of short stature that should be treated by other means. Diagnosis of growth failture due to inadequate secretion of endogenous growth hormone. Diagnosis of short stature born small for gestational age with no catch-up growth by 2 years to 4 years of age. In adults with Growth Hormone Deficiency, IGF-1 level of less than 84 ng/ml or Growth hormone stimulation tests, e.g., insulin tolerance test (ITT) with GH level of less than 5 mcg/L, GHRH with arginine with GH level of less than 4.1 mcg/L.

Age Restrictions

N/A

Prescriber Restrictions

Endocrinologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

HUMIRA

Affected Drugs

HUMIRA®
HUMIRA PEDIATRIC CROHNS®
HUMIRA PEN®
HUMIRA PEN-CD/UC/HS STARTER®
HUMIRA PEN-PS/UV STARTER®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with biologic DMARDs (e.g., TNF Antagonists)

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist, Dermatologist, Gastroenterologist, Ophthalmologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with Rheumatoid Arthritis or Polyarticular-Course Juvenile Rheumatoid Arthritis, the use of at least one conventional Disease-Modifying Anti-Rheumatic Drug (e.g., methotrexate, sulfasalazine, etc.) is required for the current condition prior to the initiation of Humira. In patients with Ankylosing Spondylitis, the use of at least 1 NSAID is required for the current condition prior to the initiation of Humira. In patients with plaque psoriasis, the use of at least one systemic therapy (e.g., methotrexate, cyclosporine, acitretin, etc.) is required prior to the initiation of Humira if a patient is a candidate for systemic therapy. In patients with moderately to severely active ulcerative colitis, the use of at least one conventional therapy agent (e.g., a corticosteroid, azathioprine, or 6-mercaptopurine, etc.) is required prior to initiation of Humira. For the indications listed above, the use of at least one prerequisite drug is not required in patients who have already tried a biologic. In patients with Psoriatic Arthritis,

Hidradenitis Suppurativa, or Crohn's disease, the use of a pre-requisite drug is not required prior to the initiation of Humira.

HYDROXYZINE

Affected Drugs

HYDROXYZINE

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for 3 months.

Other Criteria

A clinical justification indicating that the benefit of hydroxyzine outweighs the potential risks will be required in members 65 years of age and older.

IBRANCE

Affected Drugs

IBRANCE®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong CYP3A inducers (e.g. phenytoin, rifampin, carbamazepine, enzalutamide, etc.). Interstitial Lung Disease (ILD) or Pneumonitis.

Required Medical Information

In patients with a diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer confirmed via testing, Ibrance will be used in combination with an 1) aromatase inhibitor (e.g., letrozole, etc.) as initial endocrine-based therapy in pre/perimenopausal or postmenopausal women or in men OR 2) fulvestrant in patients with disease progression following endocrine therapy. In patients with a diagnosis of endocrine-resistant, PIK3CA-mutated, HR-positive, HER2-negative, locally advanced or metastatic breast cancer, as detected by an FDA-approved test (e.g., FoundationOne Liquid CDx, etc.), Ibrance will be used in combination with inavolisib and fulvestrant, following recurrence on or after completing adjuvant endocrine therapy. Baseline CBC.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ICATIBANT

Affected Drugs

ICATIBANT

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of hereditary angioedema (HAE). The patient (or a caregiver) has received training from a healthcare provider on how to self-administer icatibant.

Age Restrictions

Approve if 18 years or older.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ICLUSIG

Affected Drugs

ICLUSIG®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis. Baseline CBC, LFTs, and eye examination prior to initiation of Iclusig.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

IDHIFA

Affected Drugs

IDHIFA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pregnancy in females of reproductive potential.

Required Medical Information

Diagnosis of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA approved test (e.g., RealTime IDH2, etc.) Baseline CBC, bilirubin and uric acid level.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

IMATINIB

Affected Drugs

IMATINIB MESYLATE
IMKELDI

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) Newly diagnosed Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase or 2) Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in blast crisis (BC), accelerated phase (AP), or in chronic phase (CP) after failure of interferon-alpha therapy or 3) relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) or 4) newly diagnosed Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) in combination with chemotherapy in pediatric patients or 5) myelodysplastic/myeloproliferative diseases (MDS/MPD) associated with platelet-derived growth factor receptor (PDGFR) gene re-arrangements or 6) aggressive systemic mastocytosis (ASM) without the D816V c-Kit mutation or with c-Kit mutational status unknown or 7) hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) or 8) unresectable, recurrent and/or metastatic dermatofibrosarcoma protuberans (DFSP) or 9) Kit (CD117) positive unresectable and/or metastatic malignant gastrointestinal stromal tumors (GIST) or 10) Adjuvant treatment following resection of Kit (CD117) positive GIST

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Allergist, Immunologist, Dermatologist, or Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

IMBRUVICA

Affected Drugs

IMBRUVICA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of Waldenstrom's macroglobulinemia (WM) or chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) or chronic lymphocytic leukemia (CLL) with 17p deletion or small lymphocytic lymphoma (SLL) with 17p deletion or chronic graft versus host disease

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist, Transplant specialist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

A use of at least one line systemic therapy (e.g. corticosteroid, etc.) for chronic graft versus host disease is required prior to the initiation of Imbruvica.

IMIPRAMINE

Affected Drugs

IMIPRAMINE

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

A clinical justification indicating that the benefit of imipramine outweighs the potential risks will be required in members 65 years of age and older.

INCRELEX

Affected Drugs

INCRELEX®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with secondary forms of IGF-1 deficiency, such as Growth Hormone (GH) deficiency, malnutrition, hypothyroidism, and chronic treatment with pharmacologic doses of anti-inflammatory steroids. In patients with closed epiphyses. In patients with active or suspected neoplasia. In adult patients.

Required Medical Information

In growth failure patients with Severe Primary IGF-1 deficiency, Severe Primary IGF-1 deficiency is defined by: height standard deviation score is 3.0 or less and basal IGF-1 standard deviation score is 3.0 or less and normal or elevated GH. In growth failure patients with GH gene deletion who have developed neutralizing antibodies to GH, the diagnosis must be confirmed by Laboratory or Genetic testing.

Age Restrictions

Approve in children 2 years old and older

Prescriber Restrictions

Endocrinologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

INLYTA

Affected Drugs

INLYTA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Arterial thromboembolic event (e.g., transient ischemic attack, cerebrovascular accident, myocardial infarction, retinal artery occlusion, etc.) within the previous 12 months. Venous thromboembolic event (e.g., pulmonary embolism, deep vein thrombosis, retinal vein occlusion, retinal vein thrombosis, etc.) within the previous 6 months. Untreated brain metastasis. Recent active gastrointestinal bleeding. Reversible posterior leukoencephalopathy syndrome with previous Inlyta treatment. Severe hepatic impairment.

Required Medical Information

Inlyta will be used 1) in combination with avelumab, for the first-line treatment in patients with advanced renal cell carcinoma (RCC), or 2) in combination with pembrolizumab, for the first-line treatment in patients with advanced RCC or 3) as a single agent, for the treatment in patients with advanced RCC after a trial of at least one prior systemic therapy (e.g., sunitinib, temsirolimus, pazopanib, interleukin-2 (IL-2), sorafenib, everolimus, etc.). Well-controlled blood pressure prior to initiating Inlyta. Baseline thyroid function tests, baseline liver function tests (AST, ALT, bilirubin) and baseline test to monitor for proteinuria are required prior to initiation of Inlyta.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

INQOVI

Affected Drugs

INQOVI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of myelodysplastic syndromes (MDS), including previously treated and untreated, de novo and secondary MDS with the following French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups. Baseline CBC.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

INREBIC

Affected Drugs

INREBIC®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis.

Age Restrictions

N/A

Prescriber Restrictions

Hematologist, Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ITOVEBI

Affected Drugs

ITOVEBI™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of endocrine-resistant, PIK3CA-mutated, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer, as detected by an FDA-approved test (e.g., FoundationOne Liquid CDx, etc.), following recurrence on or after completing adjuvant endocrine therapy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

IVABRADINE

Affected Drugs

IVABRADINE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Acute decompensated heart failure. Clinically significant hypotension. Sink sinus syndrome, sinoatrial block or 3rd degree AV block, unless a functioning demand pacemaker is present. Clinically significant bradycardia. Severe hepatic impairment. Heart rate maintained exclusively by the pacemaker. In combination with strong CYP3A4 inhibitors (e.g., itraconazole, clarithromycin, nelfinavir, nefazodone, etc.).

Required Medical Information

Ivabradine will be used (1) to reduce the risk of hospitalization for worsening heart failure in adults with stable, symptomatic chronic heart failure (CHF) with left ventricular ejection fraction 35% or less, who are in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute or (2) for the treatment of stable symptomatic heart failure due to dilated cardiomyopathy (DCM) in pediatric patients aged 6 months and older, who are in sinus rhythm with an elevated heart rate.

Age Restrictions

N/A

Prescriber Restrictions

Cardiologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In adults with CHF, patient has NYHA Class II, III, or IV symptoms and is currently receiving maximally tolerated doses of beta-blockers unless contraindicated.

IWILFIN

Affected Drugs

IWILFIN™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of high-risk neuroblastoma (HRNB) with at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy. Baseline CBC, LFTs.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

JAKAFI

Affected Drugs

JAKAFI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

The diagnosis of 1) intermediate or high-risk myelofibrosis (including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis) or 2) polycythemia vera or 3) steroid-refractory acute graft-versus-host disease or 4) chronic graft-versus-host disease after failure of at least one line of systemic therapy. Baseline CBC, liver and renal function tests. The platelet count is equal to or greater than 50 X 10(9)/L.

Age Restrictions

Acute and chronic graft-versus-host disease: 12 years and older.

Prescriber Restrictions

Hematologist, Oncologist, Transplant Specialist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with polycythemia vera, a use of hydroxyurea, Pegasys, or Besremi is required prior to initation of Jakafi.

JAYPIRCA

Affected Drugs

JAYPIRCA™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) relapsed or refractory mantle cell lymphoma after at least two lines of systemic therapy, including a BTK inhibitor or 2) chronic lymphocytic leukemia or small lymphocytic lymphoma after at least two prior lines of therapy, including a BTK inhibitor and a BCL-2 inhibitor. Baseline CBC.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of Calquence or Imbruvica is required prior to the initiation of Jaypirca.

KALYDECO

Affected Drugs

KALYDECO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Kalydeco is used concomitantly with strong CYP3A inducers (e.g., rifampin, etc.). Patient is homozygous for the F508del mutation in the CFTR gene.

Required Medical Information

Diagnosis of cystic fibrosis (CF) in patients who have one mutation in the CFTR gene that is responsive to ivacaftor potentiation (if the patient's genotype is unknown, an FDA-cleared CF mutation test will be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use). Baseline liver function tests (AST, ALT).

Age Restrictions

Approve if 1 month or older.

Prescriber Restrictions

Pulmonologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

KERENDIA

Affected Drugs

KERENDIA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with spironolactone or eplerenone.

Required Medical Information

Initiation: Diagnosis of chronic kidney disease associated with type 2 diabetes. Estimated glomerular filtration rate greater than or equal to 25 mL/min/1.73 m2. Urine albumin-to-creatinine ratio greater than or equal to 30 mg/g. Serum potassium level less than or equal to 5.0 mEq/L. Reauthorization: Diagnosis of chronic kidney disease associated with type 2 diabetes.

Age Restrictions

18 years and older

Prescriber Restrictions

N/A

Coverage Duration

Initial: 1 year. Reauthorization: lifetime.

Other Criteria

Patient is currently receiving a maximally tolerated labeled dosage of an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB), unless contraindicated.

KISQALI

Affected Drugs

KISQALI®
KISQALI® FEMARA® CO-PACK

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of Kisqali with strong CYP3A4 inducers (e.g., phenytoin, rifampin, carbamazepine, etc.). Patients who already have or who are at significant risk of developing QTc prolongation, including patients with: long QT syndrome, uncontrolled or significant cardiac disease (including recent myocardial infarction, congestive heart failure, unstable angina and bradyarrhythmias), electrolyte abnormalities, or concomitant use with drugs that prolong the QT interval (e.g., amiodarone, disopyramide, procainamide, quinidine, sotalol, etc.).

Required Medical Information

1) Diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer (for advanced or metastatic breast cancer, Kisqali will be used in combination with a) an aromatase inhibitor (e.g., letrozole, etc.) as initial endocrine-based therapy in adults or b) fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy (e.g., letrozole, exemestane, etc.) in adults) OR 2) Diagnosis of HR-positive, HER2-negative stage II and III early breast cancer at high risk of recurrence (for early breast cancer, Kisqali will be used in combination with an aromatase inhibitor (e.g., letrozole, etc.)). Baseline LFTs, CBC, ECG, and electrolytes.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

KOSELUGO

Affected Drugs

KOSELUGO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of neurofibromatosis type 1 with symptomatic, inoperable plexiform neurofibromas.

Age Restrictions

Approve if 2 years old and up to 18 years old.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved through the remainder of the contract year.

Other Criteria

N/A

KRAZATI

Affected Drugs

KRAZATI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong CYP3A4 inducers (e.g., rifampin, etc.). Interstitial Lung Disease (ILD) or Pneumonitis.

Required Medical Information

Diagnosis of (1) KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC), as determined by an FDA-approved test (e.g., therascreen KRAS RGQ PCR Kit, Agilent Resolution ctDx FIRST assay, etc.), who have received at least one prior systemic therapy or (2) KRAS G12C-mutated locally advanced or metastatic colorectal cancer (CRC) in combination with cetuximab, as determined by an FDA-approved test (e.g., therascreen KRAS RGQ PCR Kit, Agilent Resolution ctDx FIRST assay, etc.), who have received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy. Baseline LFTs.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Pulmonologist, Gastroenterologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

LAPATINIB

Affected Drugs

LAPATINIB

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Laboratory testing based on the new HER2 Testing Guidelines from the College of American Pathologists (CAP) and the American Society of Clinical Oncology (ASCO) that confirms Human Epidermal Receptor Type 2 (HER2) overexpression in the patient's tumor. Testing for hormone receptor positive metastatic breast cancer in postmenopausal women who will be prescribed lapatinib with letrozole. The patient's baseline LVEF, baseline potassium and magnesium levels are within normal limits. Liver function tests: ALT, AST, bilirubin.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of anthracycline, taxane, and trastuzumab is required prior to the initiation of lapatinib with advanced or metastatic breast cancer who will receive lapatinib in combination with capecitabine. These criteria do not apply for the other indication: in postmenopausal women with hormone receptor positive metastatic breast cancer who will receive lapatinib in combination with letrozole.

LAZCLUZE

Affected Drugs

LAZCLUZE™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong and moderate CYP3A4 inducers (e.g., rifampin, efavirenz, etc.). Interstitial Lung Disease (ILD) or Pneumonitis.

Required Medical Information

Diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations, as detected by an FDA-approved test. Lazcluze will be used in combination with Rybrevant. Baseline serum electrolytes (e.g., potassium, magnesium, etc.) and LFTs (e.g., ALT, AST, etc.).

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

LEDIPASVIR-SOFOSBUVIR

Affected Drugs

LEDIPASVIR-SOFOSBUVIR

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of hepatitis C infection confirmed via detectable serum hepatitis C virus RNA by quantitative assay. Criteria will be applied consistent with current AASLD IDSA guidance.

Age Restrictions

N/A

Prescriber Restrictions

Infectious Disease Specialist, Gastroenterologist, Hepatologist

Coverage Duration

The PA will be approved consistent with current AASLD IDSA guidance.

Other Criteria

Criteria will be applied consistent with current AASLD IDSA guidance.

LENALIDOMIDE

Affected Drugs

LENALIDOMIDE

Covered Uses

All FDA-approved Indications not otherwise excluded from Part D and some other medically accepted indications listed below under Off Label Uses field.

Off-label Uses

Treatment of multiple myeloma following autologous hematopoietic stem cell transplantation, previously treated follicular lymphoma, or previously treated marginal zone lymphoma

Exclusion Criteria

Pregnancy in females of reproductive potential.

Required Medical Information

Lenalidomide will not be used in patients with chronic lymphocytic leukemia (CLL) outside of controlled clinical trials. A diagnosis of 1) transfusion-dependent anemia due to low-or intermediate-1-risk myelodysplastic syndromes (MDS), where disease is associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities confirmed by testing, 2) multiple myeloma for combination use with dexamethasone, 3) multiple myeloma as maintenance following autologous hematopoietic stem cell transplantation (auto-HSCT), 4) mantle cell lymphoma, 5) previously treated follicular lymphoma for combination use with a rituximab product, 6) previously treated marginal zone lymphoma for combination use with a rituximab product.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist.

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with mantle cell lymphoma (MCL), disease relapse or progression on at least two prior therapies including bortezomib is required prior to the initiation of lenalidomide.

LENVIMA

Affected Drugs

LENVIMA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Lenvima will be used 1) in patients with differentiated thyroid cancer, disease is locally recurrent or metastatic, progressive, and refractory to radioactive iodine treatment or 2) in patients with advanced renal cell cancer, as the first line treatment, in combination with pembrolizumab or 3) in patients with advanced renal cell cancer, Lenvima will be used in combination with everolimus following one prior anti-angiogenic therapy or 4) in patients with unresectable hepatocellular carcinoma or 5) in patients with advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), Lenvima will be used in combination with pembrolizumab for patients who have disease progression following prior systemic therapy and are not candidates for curative surgery or radiation.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

LEUKERAN

Affected Drugs

LEUKERAN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Prior resistance to chlorambucil.

Required Medical Information

Diagnosis of 1) chronic lymphocytic leukemia or 2) malignant lymphomas including lymphosarcoma or 3) giant follicular lymphoma or 4) Hodgkin's disease. Leukeran will be used in these conditions for palliative purposes.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

LEUPROLIDE

Affected Drugs

LEUPROLIDE

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of advanced prostatic cancer undergoing palliative treatment. Baseline electrolytes (e.g., potassium, magnesium, etc.), electrocardiograms, serum testosterone, PSA

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

LEUPROLIDE DEPOT

Affected Drugs

LEUPROLIDE DEPOT

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of advanced prostate cancer.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

LIBERVANT

Affected Drugs

LIBERVANT™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if 2 years and up to 5 years of age.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

LIDOCAINE PATCH

Affected Drugs

LIDOCAINE PATCH

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved through the remainder of the contract year.

Other Criteria

N/A

LIVTENCITY

Affected Drugs

LIVTENCITY®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of post-transplant CMV infection/disease that is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir or foscarnet.

Age Restrictions

Approve if 12 years or older.

Prescriber Restrictions

Infectious Disease Specialist, Transplant specialist, Oncologist

Coverage Duration

The PA will be approved for 3 months.

Other Criteria

N/A

LONSURF

Affected Drugs

LONSURF®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Confirmed diagnosis of 1) metastatic colorectal cancer when Lonsurf is used as a single agent or in combination with bevacizumab or 2) metastatic gastric or gastroesophageal junction adenocarcinoma. Baseline complete blood count (CBC) and platelet count.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with colorectal cancer, the use of fluoropyrimidine-oxaliplatin-irinotecan-based therapy, an anti-VEGF biological therapy, and, if RAS wild-type, an anti-EGFR therapy are required prior to the initiation of Lonsurf. In patients with metastatic gastric or gastroesophageal junction adenocarcinoma, the use of at least two prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy are required prior to the initiation of Lonsurf.

LORBRENA

Affected Drugs

LORBRENA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong CYP3A4 inducers (e.g., rifampin, etc.). Interstitial lung disease or Pneumonitis.

Required Medical Information

Diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test (e.g., VENTANA ALK (D5F3) CDx Assay, etc.).

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of Alecensa is required prior to the initiation of Lorbrena.

LUMAKRAS

Affected Drugs

LUMAKRAS™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong CYP3A4 inducers (e.g., rifampin, etc.). Interstitial Lung Disease (ILD) or Pneumonitis.

Required Medical Information

Diagnosis of 1) KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC), as determined by an FDA-approved test (e.g., therascreen KRAS RGQ PCR Kit, Guardant360 CDx, etc.), in patients who have received at least one prior systemic therapy or 2) KRAS G12C-mutated metastatic colorectal cancer (mCRC), as determined by an FDA approved-test (e.g., QIAGEN therascreenÂ¿ KRAS RGQ PCR Kit, etc.), in patients who have received prior fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, to be used in combination with panitumumab. Baseline LFTs (ALT, AST, and total bilirubin).

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Gastroenterologist, Pulmonologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

LUPRON DEPOT

Affected Drugs

LUPRON DEPOT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In women who are or may become pregnant, or who are breastfeeding. Undiagnosed abnormal vaginal bleeding.

Required Medical Information

Diagnosis of 1) advanced prostatic cancer 2) endometriosis (including pain relief, reduction of endometriotic lesion, and recurrence of symptoms) or 3) uterine leiomyomata. In patients with advanced prostatic cancer, baseline serum testosterone, PSA.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

LUPRON DEPOT PED

Affected Drugs

LUPRON DEPOT PED®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pregnancy

Required Medical Information

Diagnosis of central precocious puberty.

Age Restrictions

Approve if a pediatric patient 1 years of age or older.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

LUTRATE DEPOT

Affected Drugs

LUTRATE DEPOT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of advanced prostate cancer.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

LYNPARZA

Affected Drugs

LYNPARZA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis with mutations as detected by an FDA-approved test (e.g., BRACAnalysis CDx, etc.), where applicable, based on the FDA-approved indication.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

LYTGOBI

Affected Drugs

LYTGOBI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with dual P-gp and strong CYP3A inhibitors (e.g., itraconazole, etc.) and dual P-gp and strong CYP3A inducers (e.g., rifampin, etc.).

Required Medical Information

Diagnosis of previously treated unresectable, locally advanced or metastatic intrahepatic cholangiocarcinoma harboring fibroblast growth factor receptor 2 (FGFR2) gene fusions or other rearrangements, confirmed by next generation sequencing. Baseline phosphate levels.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

MEKINIST

Affected Drugs

MEKINIST®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with colorectal cancer, interstitial lung disease or pneumonitis.

Required Medical Information

Diagnosis of unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test when Mekinist will be used as a single agent. A Diagnosis of (1) unresectable or metastatic melanoma with BRAF V600E or V600K mutation as detected by an FDA-approved test (e.g., the THxID BRAF kit, etc.), (2) metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test (e.g., Oncomine Dx Target Test, etc.), (3) locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and with no satisfactory locoregional treatment options, (4) adjuvant treatment of patients with melanoma with BRAF V600E or V600K mutations, as detected by an FDA-approved test and involvement of lymph node(s) following complete resection, (5) unresectable or metastatic solid tumors with BRAF V600E mutation in patients who have progressed following prior treatment and have no satisfactory alternative treatment options, or (6) low-grade glioma (LGG) with a BRAF V600E mutation requiring systemic therapy. In patients with NSCLC, or ATC, or unresectable or metastatic solid tumors, or as adjuvant treatment in patients with melanoma, or LGG, Mekinist will be used in combination with dabrafenib (Tafinlar). Baseline left ventricular ejection fraction obtained via ECHO or MUGA. Baseline ophthalmologic evaluation.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

MEKTOVI

Affected Drugs

MEKTOVI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test (e.g., Oncomine Dx Target Test, etc.), in combination with encorafenib or 2) metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation, as detected by an FDA-approved test, in combination with encorafenib. Baseline LFTs, serum CPK, creatinine levels, and ophthalmic evaluation.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, the use of Cotellic or Mekinist is required prior to the initiation of Mektovi. In patients with metastatic NSCLC with a BRAF V600E mutation, the use of Mekinist is required prior to the initiation of Mektovi

METYROSINE

Affected Drugs

METYROSINE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of pheochromocytoma. Metyrosine will not be used in patients for the treatment of essential hypertension.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

MIFEPRISTONE

Affected Drugs

MIFEPRISTONE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pregnancy in females of reproductive potential. Use of simvastatin, lovastatin, and CYP3A substrates with narrow therapeutic range (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, tacrolimus, etc.). In women with history of unexplained vaginal bleeding. In women with endometrial hyperplasia with atypia or endometrial carcinoma. In patients who require concomitant treatment with systemic corticosteroids for serious medical conditions or illnesses (e.g., immunosuppression after organ transplantation).

Required Medical Information

Diagnosis of hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing's syndrome who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery.

Age Restrictions

N/A

Prescriber Restrictions

Endocrinologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

MIGLUSTAT

Affected Drugs

MIGLUSTAT
YARGESA

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

The diagnosis must be confirmed by laboratory or Genetic testing. Intolerance to Enzyme Replacement Therapy, such as allergy, hypersensitivity, or poor venous access.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

MODAFINIL

Affected Drugs

MODAFINIL

Covered Uses

All FDA-approved Indications not otherwise excluded from Part D and some other medically accepted indications listed below under Off Label Uses field.

Off-label Uses

Treatment of idiopathic hypersomnia.

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of excessive sleepiness associated with 1) narcolepsy confirmed by a sleep study, 2) obstructive sleep apnea, or 3) shift work disorder, or 4) diagnosis of Idiopathic Hypersomnia confirmed by a sleep study as defined by the International Classification of Sleep Disorders.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

NAYZILAM

Affected Drugs

NAYZILAM®

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

A clinical justification indicating that the benefit of nayzilam outweighs the potential risks will be required in members 65 years of age and older

NERLYNX

Affected Drugs

NERLYNX®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of Nerlynx with strong CYP3A4 inducers (e.g., phenytoin, rifampin, carbamazepine, etc.), or strong CYP3A4 inhibitors (e.g., ketoconazole, clarithromycin, voriconazole, etc.). In patients experiencing Grade 3 or Grade 4 liver abnormalities. In women who are or may become pregnant, or who are breastfeeding.

Required Medical Information

Diagnosis of 1) early stage HER2-overexpressed/amplified breast cancer or 2) advanced or metastatic HER2-positive breast cancer. In patients with advanced or metastatic HER2-positive breast cancer, Nerlynx will be used in combination with capecitabine. Baseline LFTs.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with early stage HER2-positive breast cancer, treatment with trastuzumab based therapy is required prior to the initiation of Nerlynx. In patients with advanced or metastatic HER2-positive breast cancer, the use of at least two anti-HER2 based regimens is required prior to the initiation of Nerlynx.

NINLARO

Affected Drugs

NINLARO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of multiple myeloma. Ninlaro will be used in combination with lenalidomide and dexamethasone. Baseline absolute neutrophil count is equal to or greater than 1,000/mm3. Baseline platelet count is equal to or greater than 75,000/mm3.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

At least one prior therapy (e.g., bortezomib, thalidomide, etc.) is required prior to the initiation of Ninlaro.

NITISINONE

Affected Drugs

NITISINONE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

The diagnosis must be confirmed by laboratory or genetic testing.

Age Restrictions

N/A

Prescriber Restrictions

The prescription is recommended or initially written by gastroenterologist, hematologist, metabolic specialist, nephrologist or other specialist experienced in the treatment of Hereditary Tyrosinemia type 1.

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

NIVESTYM

Affected Drugs

NIVESTYM®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Baseline complete blood count (CBC) and platelet count.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist, or Infectious Disease Specialist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

NUBEQA

Affected Drugs

NUBEQA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Concomitant use with combined P-gp and strong or moderate CYP3A inducers (e.g., rifampicin, etc.).

Required Medical Information

Diagnosis of 1) non-metastatic castration-resistant prostate cancer or 2) metastatic castration-sensitive prostate cancer or 3) metastatic castration sensitive prostate cancer in combination with docetaxel. Concurrent use of Nubeqa with a gonadotropin-releasing hormone (GnRH) analog unless the patient has had a bilateral orchiectomy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Urologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

NUEDEXTA

Affected Drugs

NUEDEXTA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Concomitant use with quinidine, quinine, or mefloquine or MAOI. In patients with a history of quinidine, quinine or mefloquine-induced thrombocytopenia, hepatitis, or other hypersensitivity reactions. In patients with prolonged QT interval, congenital long QT syndrome, history suggestive of torsades de pointes, heart failure, atrioventricular (AV) block without implanted pacemaker, or patients at high risk of complete AV block. Concomitant use with drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine or pimozide).

Required Medical Information

Diagnosis of pseudobulbar affect

Age Restrictions

N/A

Prescriber Restrictions

Neurologist, Psychiatrist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

NUPLAZID

Affected Drugs

NUPLAZID™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with hepatic impairment.

Required Medical Information

Diagnosis of hallucinations and delusions associated with Parkinson's disease psychosis.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist, Psychiatrist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

NURTEC

Affected Drugs

NURTEC®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

For the treatment of migraine, the use of at least one generic triptan therapy (e.g., sumatriptan, zolmitriptan, naratriptan, rizatriptan, etc.) is required prior to initiation of Nurtec unless contraindicated or the member has had an inadequate response to triptan therapy. For the prevention of episodic migraine, the use of at least one standard generic preventative antimigraine therapy (for example, beta blocker (e.g., propranolol, metoprolol, etc.) or antidepressant (e.g., venlafaxine, etc.), or anticonvulsant (e.g., topiramate, divalproex, etc.)) is required prior to initiation of Nurtec unless contraindicated or the member has had an inadequate response.

OCTREOTIDE

Affected Drugs

OCTREOTIDE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of (1) acromegaly in patients who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses or (2) metastatic carcinoid tumors with symptoms of severe diarrhea and flushing episodes or (3) profuse watery diarrhea associated with Vasoactive Intestinal Peptide-secreting tumors.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with acromegaly, patient has blood levels of growth hormone (GH) and insulin growth factor-1 (IGF-1) above the upper limit of normal based on age and gender for the reporting laboratory.

ODOMZO

Affected Drugs

ODOMZO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

A confirmed negative pregnancy test for women of childbearing age prior to initiation of therapy. Confirmed diagnosis of locally advanced basal cell carcinoma (BCC). BCC recurrence following surgery or radiation is required if a patient is a candidate for surgery or radiation. Baseline serum creatine kinase (CK) and creatinine levels.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

OFEV

Affected Drugs

OFEV®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Moderate or severe hepatic impairment (Child-Pugh Class B or C).

Required Medical Information

Confirmed diagnosis of 1) idiopathic pulmonary fibrosis (e.g., by high-resolution computed tomography (HRCT) demonstrating usual interstitial pneumonia (UIP), etc.) or 2) systemic sclerosis-associated interstitial lung disease (SSc-ILD) or 3) chronic fibrosing interstitial lung diseases with a progressive phenotype. Baseline liver function tests: ALT, AST, bilirubin.

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

OGSIVEO

Affected Drugs

OGSIVEO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of strong or moderate CYP3A inhibitors (e.g., clarithromycin, itraconazole, ketoconazole, erythromycin, fluconazole, etc.) OR strong or moderate CYP3A inducers (e.g., rifampin, efavirenz, etc.).

Required Medical Information

Ogsiveo will be used in adult patients with progressing desmoid tumors who require systemic treatment.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

OJEMDA

Affected Drugs

OJEMDA™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong or moderate CYP2C8 inhibitors (e.g., clopidogrel, etc.) or inducers (e.g., rifampin, etc.).

Required Medical Information

Diagnosis of relapsed or refractory pediatric low-grade glioma (LGG) harboring a BRAF fusion or rearrangement, or BRAF V600 mutation.

Age Restrictions

Approve if 6 months of age or older

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

OJJAARA

Affected Drugs

OJJAARA

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of intermediate or high-risk myelofibrosis (MF), including primary MF or secondary MF [post-polycythemia vera (PV) or post-essential thrombocythemia (ET)], in adults with anemia. Baseline CBC, liver function tests: ALT, AST, bilirubin.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ONUREG

Affected Drugs

ONUREG®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of acute myeloid leukemia in patients who have achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy and are not able to complete intensive curative therapy. Baseline CBC.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

OPSUMIT

Affected Drugs

OPSUMIT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pregnancy in females of reproductive potential.

Required Medical Information

Diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1). Baseline LFTs (AST, ALT, bilirubin) and hemoglobin.

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist, Cardiologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ORENCIA

Affected Drugs

ORENCIA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with biologic DMARDs (e.g., TNF Antagonists)

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist, Hematologist, Transplant specialist, or Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with Rheumatoid Arthritis or Polyarticular-Course Juvenile Rheumatoid Arthritis, the use of at least one conventional Disease-Modifying Anti-Rheumatic Drug (e.g., methotrexate, sulfasalazine, etc.) is required for the current condition prior to the initiation of Orencia. For the indications listed above, the use of at least one prerequisite drug is not required in patients who have already tried a biologic. For prophylaxis of acute graft versus host disease (aGVHD) in patients undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor, Orencia will be used in combination with a calcineurin inhibitor and methotrexate. In patients with Psoriatic Arthritis, the use of a pre-requisite drug is not required prior to the initiation Orencia.

ORGOVYX

Affected Drugs

ORGOVYX™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of advanced prostate cancer.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Urologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ORKAMBI

Affected Drugs

ORKAMBI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong CYP3A inducers (e.g., rifampin, etc.). Concomitant use with ivacaftor.

Required Medical Information

Diagnosis of cystic fibrosis (CF) in patients who are homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene confirmed by an FDA-cleared CF mutation test. Baseline liver function tests (AST, ALT, bilirubin).

Age Restrictions

Approve if 1 years old or older.

Prescriber Restrictions

Pulmonologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ORSERDU

Affected Drugs

ORSERDU™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong CYP3A4 inducers (e.g., rifampin, etc.), moderate CYP3A4 inducers (e.g., efavirenz, etc.), strong CYP3A4 inhibitors (e.g., itraconazole, etc.), or moderate CYP3A4 inhibitors (e.g., fluconazole, etc.). Severe hepatic impairment (Child-Pugh C).

Required Medical Information

Diagnosis of ER-positive, HER2-negative, ESR1-mutated advanced or metastatic breast cancer with disease progression following at least one line of endocrine therapy in postmenopausal women or adult men. Baseline lipid panel.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

OTEZLA

Affected Drugs

OTEZLA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with biologic DMARDs (e.g., TNF Antagonists). Co-administered with strong cytochrome P450 enzyme inducers, such as rifampin, phenobarbital, carbamazepine, phenytoin, etc.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist, Dermatologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with plaque psoriasis, the use of at least one systemic therapy (e.g., methotrexate, cyclosporine, acitretin, etc.) is required prior to the initiation of Otezla if a patient is a candidate for systemic therapy. In patients with oral ulcers associated with Behcet's Disease, the use of at least one systemic therapy (e.g., azathioprine, cyclosporine, etc.) is required prior to the initiation of Otezla. For the indications listed above, the use of at least one prerequisite drug is not required in patients who have already tried a biologic. In patients with Psoriatic Arthritis, the use of a pre-requisite drug is not required prior to the initiation Otezla.

PAZOPANIB

Affected Drugs

PAZOPANIB

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pre-existing severe hepatic impairment (total bilirubin greater than 3 times upper limit of normal). Patients who were hospitalized for cerebral hemorrhage, or clinically significant GI hemorrhage in the past 6 months.

Required Medical Information

Diagnosis of 1) advanced renal cell carcinoma or 2) advanced soft tissue sarcoma after prior chemotherapy. Baseline serum liver tests: AST, ALT, bilirubin. EKG, electrolytes (e.g., calcium, magnesium, potassium), thyroid function tests, urinalysis.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

PEGASYS

Affected Drugs

PEGASYS®

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Autoimmune hepatitis. Hepatic decompensation in patients with cirrhosis.

Required Medical Information

Diagnosis of (1) Chronic Hepatitis C (CHC) in combination therapy with other hepatitis C virus (HCV) drugs in adults with compensated liver disease or as monotherapy only if patient has contraindication or significant intolerance to other HCV drugs or (2) CHC in combination with ribavirin for pediatric patients 5 years of age and older with compensated liver disease or (3) HBeAg-positive and HBeAg-negative Chronic Hepatitis B (CHB) infection in adults who have compensated liver disease and evidence of viral replication and liver inflammation or (4) HBeAg-positive CHB in non-cirrhotic pediatric patients 3 years of age and older with evidence of viral replication and elevations in serum alanine aminotransferase (ALT).

Age Restrictions

N/A

Prescriber Restrictions

Infectious Disease Specialist, Gastroenterologist, Hepatologist

Coverage Duration

The PA will be approved for one year.

Other Criteria

N/A

PEMAZYRE

Affected Drugs

PEMAZYRE™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test (i.e., FoundationOne CDx, etc.) or 2) relapsed or refractory myeloid/lymphoid neoplasms with fibroblast growth factor receptor 1 (FGFR1) rearrangement. Baseline phosphate levels and ophthalmologic examination including optical coherence tomography (OCT) prior to initiation of Pemazyre.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

PERPHENAZINE-AMITRIPTYLINE

Affected Drugs

PERPHENAZINE-AMITRIPTYLINE

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

A clinical justification indicating that the benefit of perphenazine-amitriptyline outweighs the potential risks will be required in members 65 years of age and older.

PIQRAY

Affected Drugs

PIQRAY®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of Piqray with strong CYP3A inducers (e.g., rifampin, carbamazepine, phenytoin, etc.).

Required Medical Information

Diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer as detected by an FDA-approved test (e.g., therascreen PIK3CA RGQ PCR Kit, etc.) in combination with fulvestrant in adults, following progression on or after an endocrine-based regimen. Baseline fasting plasma glucose levels and HbA1c.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

PIRFENIDONE

Affected Drugs

PIRFENIDONE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Severe hepatic impairment (Child-Pugh Class C). End stage renal disease (ESRD) requiring dialysis.

Required Medical Information

Diagnosis of idiopathic pulmonary fibrosis (e.g., via high-resolution computed tomography (HRCT) demonstrating usual interstitial pneumonia (UIP), etc.). Baseline liver function tests: ALT, AST, bilirubin.

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

POMALYST

Affected Drugs

POMALYST®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pregnancy

Required Medical Information

Diagnosis of multiple myeloma. ANC is greater than or equal to 500 per mcL. Platelet count is greater than or equal to 50,000 per mcL. Anti-coagulation prophylaxis is considered in patients with underlying risk factors for deep vein thrombosis or pulmonary embolism. In females of reproductive potential, the use of two reliable methods of contraception is required. A Diagnosis of AIDS-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART) or in patients with KS who are HIV-negative.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with multiple myeloma, at least two prior therapies including lenalidomide and bortezomib and demonstration of disease progression on or within 60 days of completion of the last therapy is required prior to initiation of Pomalyst.

POSACONAZOLE

Affected Drugs

POSACONAZOLE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concurrent use of any of the following with posaconazole: sirolimus, pimozide, quinidine, HMG-CoA reductase inhibitors primarily metabolized through CYP3A4 (e.g., atorvastatin, lovastatin, or simvastatin), or ergot alkaloids (e.g., ergotamine or dihydroergotamine)

Required Medical Information

For prevention of invasive Aspergillus and Candida infections, patients are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy.

Age Restrictions

Approve if 2 years old or older.

Prescriber Restrictions

Infectious Disease Specialist, Oncologist, Transplant Specialist, Hematologist.

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

POSACONAZOLE SUSP

Affected Drugs

POSACONAZOLE SUSP

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concurrent use of any of the following with posaconazole: sirolimus, pimozide, quinidine, HMG-CoA reductase inhibitors primarily metabolized through CYP3A4 (e.g., atorvastatin, lovastatin, or simvastatin), or ergot alkaloids (e.g., ergotamine or dihydroergotamine).

Required Medical Information

For prevention of invasive Aspergillus and Candida infections, patients are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy.

Age Restrictions

Approve if 13 years old or older.

Prescriber Restrictions

Infectious Disease Specialist, Oncologist, Transplant Specialist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of itraconazole or fluconazole is required prior to the initiation of posaconazole in patients with refractory oropharyngeal candidiasis.

PREVYMIS

Affected Drugs

PREVYMIS ™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Member is on pimozide or ergot alkaloids. Member is on pitavastatin or simvastatin co-administered with cyclosporine.

Required Medical Information

use for 1) prophylaxis of cytomegalovirus (CMV) infection in CMV-seropositive recipients of an allogeneic hematopoietic stem cell transplant or 2) prophylaxis of CMV disease in kidney transplant recipients at high risk (Donor CMV seropositive/Recipient CMV seronegative).

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist, Infection Disease Specialist, Transplant Specialist

Coverage Duration

The PA will be approved for 200 days.

Other Criteria

The use of ganciclovir or valacyclovir is required prior to the initiation of Prevymis

PROCRIT

Affected Drugs

PROCRIT®

Covered Uses

All FDA-approved Indications not otherwise excluded from Part D and some other medically accepted indications listed below under Off Label Uses field.

Off-label Uses

Treatment of anemia in low or intermediate-1 risk Myelodysplastic Syndrome patients.

Exclusion Criteria

In patients with cancer receiving hormonal agents, biologic products, or radiotherapy, unless also receiving concomitant myelosuppressive chemotherapy. In patients scheduled for surgery who are willing to donate autologous blood. In patients undergoing cardiac or vascular surgery. As a substitute for RBC transfusions in patients who require immediate correction of anemia. In patients with uncontrolled hypertension. Pure red cell aplasia (PRCA) that occurred after prior treatment with erythropoiesis-stimulating agents (e.g., epoetin alfa, etc.).

Required Medical Information

In patients with CKD, the pretreatment Hgb level is less than 10g/dL or pretreatment Hct is less than 30%. In patients with Non-Myeloid malignancies receiving concomitant myelosuppressive chemotherapy: 1) pretreatment Hgb level is less than 10 g/dL or pretreatment Hct is less than 30% and 2) chemotherapy is planned for a minimum of two additional months. In HIV-infected patients with anemia related to zidovudine-treatment, the pretreatment endogenous serum erythropoietin level is less than 500 milliunits/mL. In patients undergoing elective non-cardiac or non-vascular surgery: 1) DVT prophylaxis is considered and 2) perioperative hemoglobin is greater than 10g/dL and less than or equal to 13g/dL. In patients with low or intermediate-1 risk Myelodysplastic Syndrome: 1) patient must be transfusion-dependent or symptomatic from anemia and 2) pretreatment endogenous serum erythropoietin level is less than 500 milliunits/mL. For all uses: 1) pretreatment serum ferritin is greater than or equal to 100mcg/L or serum transferrin saturation is greater than or equal to 20%, 2) iron, folate, and vitamin B-12 deficiencies have been corrected (if any), and 3) other causes of anemia (e.g., hemolysis, bleeding, etc.) have been ruled out.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved through the remainder of the contract year.

Other Criteria

Part B coverage 1) if a prescriber (e.g., nephrologist, nurse practitioner, physician assistant, etc.) receives a monthly capitation payment to manage end-stage renal disease (ESRD) patients' care and 2) if Procrit is furnished to an ESRD patient receiving dialysis services and used for an ESRD-related condition.

PROLASTIN

Affected Drugs

PROLASTIN C®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

IgA deficient patients with antibodies against IgA.

Required Medical Information

Diagnosis of alpha1-antitrypsin deficiency with clinically evident emphysema in patients with PiZZ, PiZ(null), Pi(null)(null) or PiSZ genotypes.

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

Prolastin is subject to Part B vs. Part D determination.

PROLIA

Affected Drugs

PROLIA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Hypocalcemia. Patients on Xgeva.

Required Medical Information

History of one of the following: 1. The patient is at high risk for fractures (BMD T score below -2.5, steroids use) or has a history of an osteoporotic fracture. 2. The patient had a fracture and/ or experienced a decrease in BMD T score while on either alendronate, risedronate, ibandronate. 3. The patient is not a candidate for bisphosphonates or intolerant to them.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

Prolia is subject to Part B versus Part D determination.

PROMACTA

Affected Drugs

PROMACTA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

1) A diagnosis of thrombocytopenia in patients with chronic hepatitis C whose degree of thrombocytopenia prevents the initiation of interferon-based therapy or limits the ability to maintain interferon-based therapy or 2) a diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP): platelet count is less than 30,000/microliter or less than 50,000/microliter with the risk factors for bleeding and the patient has had an insufficient response to corticosteroids, immunoglobulins, or splenectomy or 3) a diagnosis of severe aplastic anemia in patients who have had an insufficient response to immunosuppressive therapy or 4) a diagnosis of severe aplastic anemia: Promacta will be used in combination with standard immunosuppressive therapy (e.g. corticosteroids, cyclosporine, etc). Baseline CBC. Baseline liver function tests: ALT, AST, Bilirubin.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

PYRIMETHAMINE

Affected Drugs

PYRIMETHAMINE

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with megaloblastic anemia due to folate deficiency.

Required Medical Information

Diagnosis of toxoplasmosis in combination with a sulfonamide.

Age Restrictions

N/A

Prescriber Restrictions

Infectious Disease Specialist

Coverage Duration

The PA will be approved through the remainder of the contract year.

Other Criteria

N/A

QINLOCK

Affected Drugs

QINLOCK ™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with advanced Gastrointestinal stromal tumor (GIST), the use of imatinib and at least 2 other kinase inhibitors (e.g., Ayvakit, sunitinib, Stivarga, Sprycel, etc.) is required prior to initiation of Qinlock.

QUININE SULFATE

Affected Drugs

QUININE SULFATE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients for the treatment of severe or complicated P. falciparum malaria. In patients for prevention of malaria. In patients for the treatment or prevention of nocturnal leg cramps. In patients with any of the following: 1) prolonged QT interval. 2) known hypersensitivity reactions to quinine (e.g., thrombocytopenia, idiopathic thrombocytopenia purpura (ITP) and thrombotic thrombocytopenic purpura (TTP), hemolytic uremic syndrome (HUS), blackwater fever (acute intravascular hemolysis, hemoglobinuria, and hemoglobinemia), etc.) 3) myasthenia gravis 4) optic neuritis.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

7 days

Other Criteria

In patients with Chloroquine-sensitive uncomplicated malaria, the use of chloroquine or hydroxychloroquine is required prior to the use of quinine sulfate unless the use of chloroquine or hydroxychloroquine is contraindicated.

RALDESY

Affected Drugs

RALDESY™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with or use within 14 days of stopping monoamine oxidase inhibitors (MAOIs) (e.g., linezolid, intravenous methylene blue, etc.). In patients with a history of cardiac arrhythmias. In patients with known QT prolongation. Concomitant use with drugs known to prolong QT interval, including Class 1A antiarrhythmics (e.g., quinidine, procainamide), Class 3 antiarrhythmics (e.g., amiodarone, sotalol), certain antipsychotic medications (e.g., ziprasidone, chlorpromazine, thioridazine), or certain antibiotics (e.g., gatifloxacin).

Required Medical Information

Diagnosis of major depressive disorder.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one generic formulary drug for the treatment of the current condition is required prior to the initiation of Raldesy

REGRANEX

Affected Drugs

REGRANEX

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Known neoplasm at the site of application. Pressure ulcers and venous stasis ulcers. Use in wounds that close by primary intention.

Required Medical Information

Diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

Regranex is to be used as adjunct to good ulcer care practices

RELEUKO

Affected Drugs

RELEUKO®

Covered Uses

All FDA-approved Indications not otherwise excluded from Part D and some other medically accepted indications listed below under Off Label Uses field.

Off-label Uses

Treatment of neutropenia associated with myelodysplastic syndrome, hairy cell leukemia, aplastic anemia, severe neutropenia in HIV-infected patients on antiretroviral therapy.

Exclusion Criteria

N/A

Required Medical Information

Baseline complete blood count (CBC) and platelet count.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist, or Infectious disease specialist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

RELISTOR

Affected Drugs

RELISTOR®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Patients with known or suspected mechanical gastrointestinal obstruction and at increased risk of recurrent obstruction.

Required Medical Information

History of opioid-induced constipation (OIC) in patients with 1) chronic non-cancer pain or 2) advanced illness who are receiving palliative care (e.g., end-stage COPD/emphysema, cardiovascular disease, heart failure, Alzheimer's disease/dementia, HIV/AIDS, incurable cancer or any other advanced illness that requires a palliative opioid therapy).

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one formulary laxative (e.g. lactulose, enulose, etc.) for the current condition is required prior to the initiation of Relistor.

REPATHA

Affected Drugs

REPATHA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Repatha will be used (1) in adults with established cardiovascular disease (CVD) to reduce the risk of myocardial infarction, stroke, and coronary revascularization or (2) as an adjunct to diet, alone or in combination with other low-density lipoprotein cholesterol (LDL-C)-lowering therapies, in adults with primary hyperlipidemia, including heterozygous familial hypercholesterolemia (HeFH), to reduce LDL-C or (3) as an adjunct to diet and other LDL-C-lowering therapies in patients with HeFH, to reduce LDL-C or (4) as an adjunct to other LDL-C-lowering therapies in patients with homozygous familial hypercholesterolemia (HoFH), to reduce LDL-C.

Age Restrictions

HoFH or HeFH: 10 years old or older. All others: 18 years old or older.

Prescriber Restrictions

Cardiologist, endocrinologist, or physician who focuses in the treatment of cardiovascular (CV) risk management and/or lipid disorders.

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with primary hyperlipidemia including HeFH or established CVD: the patient has tried one high-intensity statin (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than or equal to 20 mg daily) plus an ezetimibe product concomitantly, for 8 weeks or longer and LDL-C remains 70mg/dL or higher, unless

patient is statin intolerant as demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR has had skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the symptoms resolved upon discontinuation. In patients with HoFH: the patient has tried at least one high-intensity statin (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than or equal to 20 mg daily) for 8 weeks or longer and LDL-C level remains above goal, unless patient is statin intolerant as demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR has had skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the symptoms resolved upon discontinuation.

RETACRIT

Affected Drugs

RETACRIT®

Covered Uses

All FDA-approved Indications not otherwise excluded from Part D and some other medically accepted indications listed below under Off Label Uses field.

Off-label Uses

Treatment of anemia in low or intermediate-1 risk Myelodysplastic Syndrome patients.

Exclusion Criteria

In patients with cancer receiving hormonal agents, biologic products, or radiotherapy, unless also receiving concomitant myelosuppressive chemotherapy. In patients scheduled for surgery who are willing to donate autologous blood. In patients undergoing cardiac or vascular surgery. As a substitute for RBC transfusions in patients who require immediate correction of anemia. In patients with uncontrolled hypertension. Pure red cell aplasia (PRCA) that occurred after prior treatment with erythropoiesis-stimulating agents (e.g., epoetin alfa, etc.).

Required Medical Information

In patients with CKD, the pretreatment Hgb level is less than 10g/dL or pretreatment Hct is less than 30%. In patients with Non-Myeloid malignancies receiving concomitant myelosuppressive chemotherapy: 1) pretreatment Hgb level is less than 10 g/dL or pretreatment Hct is less than 30% and 2) chemotherapy is planned for a minimum of two additional months. In HIV-infected patients with anemia related to zidovudine-treatment, the pretreatment endogenous serum erythropoietin level is less than 500 milliunits/mL. In patients undergoing elective non-cardiac or non-vascular surgery: 1) DVT prophylaxis is considered and 2) perioperative hemoglobin is greater than 10g/dL and less than or equal to 13g/dL. In patients with low or intermediate-1 risk Myelodysplastic Syndrome: 1) patient must be transfusion-dependent or symptomatic from anemia and 2) pretreatment endogenous serum erythropoietin level is less than 500 milliunits/mL. For all uses: 1) pretreatment serum ferritin is greater than or equal to 100mcg/L or serum transferrin saturation is greater than or equal to 20%, 2) iron, folate, and vitamin B-12 deficiencies have been corrected (if any), and 3) other causes of anemia (e.g., hemolysis, bleeding, etc.) have been ruled out.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved through the remainder of the contract year.

Other Criteria

Part B coverage 1) if a prescriber (e.g., nephrologist, nurse practitioner, physician assistant, etc.) receives a monthly capitation payment to manage end-stage renal disease (ESRD) patients' care and 2) if Retacrit is furnished to an ESRD patient receiving dialysis services and used for an ESRD-related condition.

RETEVMO

Affected Drugs

RETEVMO™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong CYP3A inducers (e.g., rifampin, etc.) or moderate CYP3A inducers (e.g., efavirenz, etc.).

Required Medical Information

Diagnosis of 1) locally advanced or metastatic non-small cell lung cancer (NSCLC) with a rearranged during transfection (RET) gene fusion, as detected by an FDA-approved test or 2) advanced or metastatic medullary thyroid cancer (MTC) with a RET mutation, as detected by an FDA-approved test, in patients who require systemic therapy or 3) advanced or metastatic thyroid cancer with a RET gene fusion, as detected by an FDA-approved test, in patients who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate) or 4) locally advanced or metastatic solid tumors with a RET gene fusion in patients who have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

REVLIMID

Affected Drugs

REVLIMID®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pregnancy in females of reproductive potential.

Required Medical Information

Revlimid will not be used in patients with chronic lymphocytic leukemia (CLL) outside of controlled clinical trials. A documented diagnosis of 1) transfusion-dependent anemia due to low-or intermediate-1-risk myelodysplastic syndromes (MDS), where disease is associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities confirmed by testing, 2) multiple myeloma for combination use with dexamethasone, 3) multiple myeloma as maintenance following autologous hematopoietic stem cell transplantation (auto-HSCT), 4) mantle cell lymphoma, 5) previously treated follicular lymphoma for combination use with a rituximab product, 6) previously treated marginal zone lymphoma for combination use with a rituximab product.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with mantle cell lymphoma (MCL), documented disease relapse or progression on at least two prior therapies including bortezomib is required prior to the initiation of Revlimid.

REVUFORJ

Affected Drugs

REVUFORJ®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong or moderate CYP3A4 inducers (e.g., rifampicin, etc.).

Required Medical Information

Diagnosis of relapsed or refractory acute leukemia with a lysine methyltransferase 2A gene (KMT2A) translocation.

Age Restrictions

N/A

Prescriber Restrictions

Hematologist, Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

REZLIDHIA

Affected Drugs

REZLIDHIA™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong CYP3A inducers (e.g., rifampin, etc.).

Required Medical Information

Susceptible IDH1 mutation as detected by an FDA-approved test (e.g., Abbott RealTime IDH1, etc.) in adult patients with relapsed or refractory acute myeloid leukemia. Baseline LFTs.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

RINVOQ

Affected Drugs

RINVOQ

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with other JAK inhibitors, or with biologic DMARDs (e.g., TNF Antagonists), or with biologic immunomodulators, or with other biological therapies, or with potent immunosuppressants, such as azathioprine or cyclosporine

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist, Dermatologist, Gastroenterologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with Rheumatoid Arthritis or Psoriatic Arthritis or active Ankylosing Spondylitis, or Non-radiographic Axial Spondyloarthritis, or moderately to severely active Ulcerative Colitis, or moderately to severely active Crohn's disease, or active polyarticular juvenile idiopathic arthritis, the use of at least one TNF blocker is required (unless unable to tolerate) prior to initiation of Rinvoq. In patients with refractory, moderate to severe Atopic Dermatitis, the use of at least one other systemic drug therapy (e.g., an oral corticosteroid, azathioprine, cyclosporine, mycophenolate mofetil, etc.) is required (unless unable to tolerate) prior to initiation of Rinvoq. In patients with Giant Cell Arteritis, the use of at least one systemic corticosteroid is required (unless unable to tolerate) prior to initiation of Rinvoq.

ROMVIMZA

Affected Drugs

ROMVIMZA™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT) where surgical resection will potentially cause worsening functional limitation or severe morbidity to the patient. Baseline LFTs.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ROZLYTREK

Affected Drugs

ROZLYTREK™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) metastatic non-small cell lung cancer (NSCLC) whose tumors are ROS1-positive or 2) solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, AND have progressed following treatment or have no satisfactory alternative therapy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

RUBRACA

Affected Drugs

RUBRACA™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Rubraca will be used 1) as a maintenance treatment in adult patients with deleterious BRCA mutation (germline and/or somatic) associated recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy or 2) in adult patients with a deleterious BRCA mutation (germline and/or somatic)-associated metastatic castration-resistant prostate cancer who have been treated with androgen receptor-directed therapy and a taxane-based chemotherapy. Baseline CBC.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

RUFINAMIDE

Affected Drugs

RUFINAMIDE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Patients with Familial Short QT syndrome

Required Medical Information

Diagnosis of seizures associated with Lennox-Gastaut Syndrome as adjunctive treatment

Age Restrictions

Approve if 1 year or older.

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

RYDAPT

Affected Drugs

RYDAPT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of Rydapt with strong CYP3A inducers (e.g., rifampin, carbamazepine, phenytoin, etc).

Required Medical Information

Diagnosis of 1) acute myeloid leukemia (AML) that is FLT3 mutation-positive as detected by an FDA-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay, etc.), 2) aggressive systemic mastocytosis (ASM), 3) systemic mastocytosis with associated hematological neoplasm (SM-AHN), or 4) mast cell leukemia. For AML, Rydapt will be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation. Baseline CBC and platelets.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Allergist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

SCEMBLIX

Affected Drugs

SCEMBLIX®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of Scemblix with itraconazole oral solution containing hydroxypropyl-beta-cyclodextrin.

Required Medical Information

Diagnosis of 1) Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP) or 2) previously treated Ph+ CML in CP or 3) Ph+ CML in CP with the T315I mutation. Baseline CBC, serum lipase and amylase.

Age Restrictions

N/A

Prescriber Restrictions

Hematologist, Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

SECUADO

Affected Drugs

SECUADO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Dementia-related psychosis. Severe hepatic impairment (Child-Pugh C).

Required Medical Information

Diagnosis of schizophrenia.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

SIGNIFOR

Affected Drugs

SIGNIFOR®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with hypokalemia, hypomagnesemia, or severe hepatic impairment (Child Pugh C).

Required Medical Information

Adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative. A 24-hr urine cortisol to confirm Cushing's disease. Baseline fasting plasma glucose levels, HgA1C, liver function tests, gallbladder ultrasound, electrocardiogram.

Age Restrictions

N/A

Prescriber Restrictions

Endocrinologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

SILDENAFIL CITRATE TABS 20MG

Affected Drugs

SILDENAFIL CITRATE 20MG

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

The concurrent use of nitrates (e.g., nitroglycerin, isosorbide mononitrate or dinitrate, etc.) or guanylate cyclase (GC) stimulators (e.g., riociguat, etc.). The concomitant use of sildenafil citrate with potent CYP 3A inhibitors (e.g., ritonavir, etc). Co-administration of sildenafil citrate with PDE5 inhibitors (e.g., tadalafil, etc).

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

SKYRIZI

Affected Drugs

SKYRIZI™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with biologic DMARDs (e.g., TNF Antagonists)

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Dermatologist, Rheumatologist, Gastroenterologist.

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with plaque psoriasis, the use of at least one systemic therapy (e.g., methotrexate, cyclosporine, acitretin, etc.) is required prior to the initiation of Skyrizi if a patient is a candidate for systemic therapy. In patients with moderately to severely active ulcerative colitis, the use of at least one conventional therapy agent (e.g., a corticosteroid, azathioprine, or 6-mercaptopurine, etc.) is required prior to the initiation of Skyrizi. For the indications listed above, the use of at least one prerequisite drug is not required in patients who have already tried a biologic. In patients with Psoriatic Arthritis or Crohn's disease, the use of a pre-requisite drug is not required prior to the initiation of Skyrizi.

SOFOSBUVIR-VELPATASVIR

Affected Drugs

SOFOSBUVIR-VELPATASVIR

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of sofosbuvir-velpatasvir with P-gp inducers or moderate to potent CYP inducers (e.g., rifampin, St. John's wort, carbamazepine, etc.).

Required Medical Information

Diagnosis of chronic hepatitis C virus (HCV) genotypes 1a, 1b, 2, 3, 4, 5, or 6 infection confirmed via detectable serum hepatitis C virus RNA by quantitative assay. Criteria will be applied consistent with current AASLD IDSA guidance.

Age Restrictions

N/A

Prescriber Restrictions

Infectious Disease Specialist, Gastroenterologist, Hepatologist

Coverage Duration

The PA will be approved consistent with current AASLD IDSA guidance.

Other Criteria

Criteria will be applied consistent with current AASLD IDSA guidance.

SOMAVERT

Affected Drugs

SOMAVERT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

The patient has had an inadequate response to surgery and/or radiation therapy within the past 6 months if the patient was a candidate for these therapies. The patient is not responsive or intolerant to octreotide or age-adjusted IGF-1 level greater than the upper end of a normal range.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

SORAFENIB

Affected Drugs

SORAFENIB

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concurrent use with carboplatin and paclitaxel in patients with squamous cell lung cancer.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

SPRYCEL

Affected Drugs

SPRYCEL®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Sprycel will be used in patients with 1) newly diagnosed Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase, 2) chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy including imatinib, or 3) Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) with resistance or intolerance to prior therapy (e.g. imatinib, etc.). In pediatric patients with Ph+ CML in chronic phase or newly diagnosed Ph+ ALL in combination with chemotherapy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

STELARA

Affected Drugs

STELARA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with biologic DMARDs (e.g., TNF Antagonists)

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist, Dermatologist, Gastroenterologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with plaque psoriasis, the use of at least one systemic therapy (e.g., methotrexate, cyclosporine, acitretin, etc.) is required prior to the initiation of Stelara if a patient is a candidate for systemic therapy. In patients with ulcerative colitis, the use of at least one conventional therapy (e.g., a corticosteroid, azathioprine, or 6-mercaptopurine, etc.) is required prior to initiation of Stelara. For the indications listed above, the use of at least one prerequisite drug is not required in patients who have already tried a biologic. In patients with Psoriatic Arthritis or Crohn's disease, the use of a pre-requisite drug is not required prior to the initiation of Stelara.

STIVARGA

Affected Drugs

STIVARGA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with severe hepatic impairment (Child-Pugh Class C)

Required Medical Information

Baseline liver function test (ALT, AST and bilirubin) prior to initiation of Stivarga. Adequately-controlled blood pressure prior to initiation of Stivarga.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with metastatic colorectal cancer, a use of fluoropyrimidine-oxaliplatin-irinotecan-based chemotherapy, an anti-VEGF therapy, and, if KRAS wild type, an anti-EGFR therapy is required prior to initiation of Stivarga. In patients with locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST), a use of imatinib and sunitinib is required prior to initiation of Stivarga. In patients with hepatocellular carcinoma, a use of sorafenib is required prior to initiation of Stivarga.

SUNITINIB

Affected Drugs

SUNITINIB

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) gastrointestinal stromal tumor (GIST) or 2) advanced renal cell carcinoma (RCC) or 3) recurrent RCC following nephrectomy as adjuvant treatment or 4) progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) in adult patients with unresectable locally advanced or metastatic disease.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with gastrointestinal stromal tumors (GIST), the use of imatinib is required prior to the initiation of sunitinib.

SYMPAZAN

Affected Drugs

SYMPAZAN™

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

A clinical justification indicating that the benefit of sympazan outweighs the potential risks will be required in members 65 years of age and older.

TABLOID

Affected Drugs®

TABLOID™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Prior resistance to thioguanine or mercaptopurine.

Required Medical Information

In patients with acute nonlymphocytic leukemias, Tabloid will be used for remission induction and remission consolidation.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TABRECTA

Affected Drugs

TABRECTA™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong CYP3A inducers (e.g., rifampicin, etc.) or moderate CYP3A inducers (e.g., efavirenz, etc.).

Required Medical Information

Diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors have a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping as detected by an FDA-approved test (e.g., FoundationOne CDx, etc.). Baseline LFTs.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TADALAFIL

Affected Drugs

ALYQ

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

The concurrent use of nitrates (e.g., nitroglycerin, isosorbide mononitrate or dinitrate, etc.) or guanylate cyclase (GC) stimulators (e.g., riociguat etc.) or potent CYP 3A inhibitors (e.g., ketoconazole, itraconazole, etc.) or PDE5 inhibitors (e.g., tadalafil, sildenafil, etc) or potent inducers of CYP3A (e.g., rifampin).

Required Medical Information

Diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1)

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist, Cardiologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TADALAFIL BPH

Affected Drugs

TADALAFIL BPH

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with nitrates, PDE5 inhibitors (e.g., Adcirca, Viagra, Revatio, etc.), alpha blockers (e.g., tamsulosin, terazosin, doxazosin, etc.), or guanylate cyclase stimulators (e.g., riociguat). Myocardial infarction within the last 90 days. Unstable angina. New York Heart Association Class 2 or greater heart failure in the last 6 months. Uncontrolled arrhythmias, hypotension (less than 90/50 mm Hg), or uncontrolled hypertension. Stroke within the past 6 months.

Required Medical Information

Diagnosis of Benign Prostatic Hyperplasia (BPH).

Age Restrictions

N/A

Prescriber Restrictions

Urologist

Coverage Duration

The PA will be approved for one year.

Other Criteria

In patients with BPH, the use of at least one formulary alpha blocker (e.g., tamsulosin, alfuzosin, doxazosin, terazosin, or prazosin, etc.) AND at least one formulary 5-Alpha-Reductase Inhibitor (e.g., finasteride, dutasteride, etc.) for the current condition are required prior to initiation of tadalafil.

TAFINLAR

Affected Drugs

TAFINLAR®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with colorectal cancer or in patients with wild-type BRAF solid tumors.

Required Medical Information

Diagnosis of unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test when Tafinlar will be used as a single agent. A Diagnosis of (1) unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test, when Tafinlar will be used in combination with Mekinist, (2) metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test (e.g., Oncomine Dx Target Test, etc.), (3) locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and with no satisfactory locoregional treatment options, (4) adjuvant treatment of patients with melanoma with BRAF V600E or V600K mutations, as detected by an FDA-approved test and involvement of lymph node(s) following complete resection, (5) unresectable or metastatic solid tumors with BRAF V600E mutation in patients who have progressed following prior treatment and have no satisfactory alternative treatment options, or (6) low-grade glioma (LGG) with a BRAF V600E mutation requiring systemic therapy. In patients with NSCLC, or ATC, or unresectable or metastatic solid tumors, or as adjuvant treatment in patients with melanoma, or LGG, Taflinlar will be used in combination with trametinib (Mekinist). Baseline dermatologic evaluation.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TAGRISSO

Affected Drugs

TAGRISSO™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of (1) metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test (e.g., cobas EGFR Mutation Test v2, FoundationOne CDx, etc.), or (2) NSCLC whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test (e.g., cobas EGFR Mutation Test v2, FoundationOne CDx, etc.) in patients after tumor resection as adjuvant therapy or (3) metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive NSCLC, as detected by an FDA-approved test (e.g., the cobas EGFR Mutation Test v2, etc.), or (4) locally advanced or metastatic NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test (e.g., cobas EGFR Mutation Test v2, FoundationOne CDx, etc.), in combination with pemetrexed and platinum-based chemotherapy, or (5) locally advanced, unresectable (stage III) NSCLC that has not progressed during or following concurrent or sequential platinum-based chemoradiation therapy with tumors that have EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test (e.g., cobas EGFR Mutation Test v2, FoundationOne CDx, etc.). Baseline ECG and electrolytes in patients with congenital long QTc syndrome, congestive heart failure, electrolyte abnormalities, or those who are taking medications known to prolong the QTc interval. Baseline left ventricular ejection fraction (LVEF) measurement obtained via ECHO or MUGA.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

Disease progression following treatment with at least one prior EGFR tyrosine kinase inhibitor (TKI) therapy (e.g., afatinib, erlotinib, etc.) is required prior to the initiation of Tagrisso in patients with metastatic EGFR T790M mutation-positive NSCLC.

TALZENNA

Affected Drugs

TALZENNA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Off-label Uses

N/A

Required Medical Information

Diagnosis of 1) deleterious or suspected deleterious germline BRCA mutated (gBRCAm) HER2-negative locally advanced or metastatic breast cancer, as detected by an FDA approved test (e.g., BRACAnalysis CDx, etc.). For gBRCAm HER2-negative locally advanced or metastatic breast cancer, Talzenna will be used as a single agent OR 2) homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer (mCRPC). For HRR gene-mutated mCRPC, Talzenna will be used: a) in combination with enzalutamide AND b) concurrently with a gonadotropin-releasing hormone (GnRH) analog unless the patient has had a bilateral orchiectomy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Urologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of Lynparza is required prior to the initiation of Talzenna.

TASIGNA

Affected Drugs

TASIGNA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

The patient's QTc interval 480 msec or greater. The patient's baseline potassium and magnesium levels are not within normal limits. Concurrent use of strong CYP3A4 Inhibitors or drugs that prolong QT interval.

Required Medical Information

Philadelphia chromosome positive status is required for chronic myeloid leukemia (Ph+ CML). In adult patients, history of resistance to imatinib that is defined as one of the following: failure to achieve a complete hematologic response by 3 months, failure to achieve a cytogenic response by 6 months or major cytogenic response by 12 months, progression of disease after a previous cytogenic or hematologic response (history of resistance to imatinib is not needed if the patient is intolerant to imatinib or in newly-diagnosed patients with Ph+ CML in chronic phase). In pediatric patients, history of resistance or intolerance to at least one prior tyrosine-kinase inhibitor therapy (history of resistance to at least one prior tyrosine-kinase inhibitor therapy is not needed in newly-diagnosed patients with Ph+ CML in chronic phase). Baseline ECG. Baseline Potassium and Magnesium levels.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TASIMELTEON

Affected Drugs

TASIMELTEON

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Severe hepatic impairment (Child-Pugh Class C). Co-administration of tasimelteon with strong CYP1A2 inhibitors (e.g., fluvoxamine, etc.) or strong CYP3A4 inducers (e.g., rifampin, etc.).

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Sleep Specialist or Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TAZVERIK

Affected Drugs

TAZVERIK™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) metastatic or locally advanced epithelioid sarcoma not eligible for complete resection or 2) relapsed or refractory follicular lymphoma in patients whose tumors are positive for an EZH2 mutation as detected by an FDA-approved test (e.g., cobas EZH2 Mutation Test, etc.) and who have received at least 2 prior systemic therapies or 3) relapsed or refractory follicular lymphoma in patients who have no satisfactory alternative treatment options. Baseline CBC.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist.

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TEMAZEPAM

Affected Drugs

TEMAZEPAM

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Approve if under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for 3 months.

Other Criteria

A clinical justification indicating that the benefit of temazepam outweighs the potential risks will be required in members 65 years of age and older.

TEPMETKO

Affected Drugs

TEPMETKO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with diagnosis of interstitial lung disease (ILD) or pneumonitis. Concomitant use with dual strong CYP3A inhibitors and P-gp inhibitors OR with strong CYP3A inducers.

Required Medical Information

Diagnosis of metastatic non-small cell lung cancer (NSCLC) harboring mesenchymalepithelial transition (MET) exon 14 skipping alteration. Baseline LFTs.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TERIFLUNOMIDE

Affected Drugs

TERIFLUNOMIDE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with severe hepatic impairment. Pregnancy in females of reproductive potential. Concurrent use of leflunomide. In patients with active or chronic infection (e.g., pneumonia, aspergillosis, tuberculosis, etc.).

Required Medical Information

Diagnosis of relapsing forms of multiple sclerosis to include clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease. Recent (e.g., within six months) complete blood count (CBC). Serum ALT less than or equal to 2 times ULN is required prior to the initiation of teriflunomide.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TERIPARATIDE

Affected Drugs

TERIPARATIDE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Patients have increased baseline risk for osteosarcoma (e.g., those with Paget's disease of bone or unexplained elevations of alkaline phosphatase, pediatric and young adult patients with open epiphyses, or prior external beam or implant radiation therapy involving the skeleton)

Required Medical Information

History of one of the following: 1. The patient is at high risk for fractures (BMD T score below -2.5, steroids use) or has a history of an osteoporotic fracture. 2. The patient had a fracture and/ or experienced a decrease in BMD T score while on either alendronate, risedronate, and ibandronate. 3. The patient is not a candidate for bisphosphonates or intolerant to them.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for 2 years.

Other Criteria

N/A

TETRABENAZINE

Affected Drugs

TETRABENAZINE

Covered Uses

All FDA-approved Indications not otherwise excluded from Part D and some other medically accepted indications listed below under Off Label Uses field.

Off-label Uses

Treatment of Tardive dyskinesia, Gilles de la Tourette's syndrome

Exclusion Criteria

Actively suicidal patients, or patients with untreated or inadequately treated depression. Impaired hepatic function. Concurrent use of monoamine oxidase inhibitors, reserpine or deutetrabenazine.

Required Medical Information

Diagnosis of Huntington's disease chorea, Tardive dyskinesia, or Gilles de la Tourette's syndrome.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist, Psychiatrist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

THALOMID

Affected Drugs

THALOMID®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

In patients with Multiple Myeloma, the concurrent use of Thalomid with dexamethasone.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist, Hematologist, Dermatologist, or Infection Disease Specialist.

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

Thalomid must be prescribed by a physician registered with System for Thalomid Education and Prescribing Safety Program.

TIBSOVO

Affected Drugs

TIBSOVO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of Tibsovo with strong CYP3A inducers (e.g., rifampin, etc.). Diagnosis of Guillain-Barre syndrome.

Required Medical Information

Susceptible IDH1 mutation as detected by an FDA-approved test (e.g., Abbott RealTime IDH1, etc.) in adult patients with 1) newly-diagnosed AML who are greater than or equal 75 years old or who have comorbidities that preclude use of intensive induction chemotherapy or 2) relapsed or refractory AML or 3) relapsed or refractory myelodysplastic syndromes or 4) locally advanced or metastatic cholangiocarcinoma who have been previously treated.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TRACLEER

Affected Drugs

TRACLEER®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pregnancy in females of reproductive potential.

Required Medical Information

Diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1) in patients with NYHA Functional Class II-IV symptoms. Baseline LFTs (ALT, AST, bilirubin).

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist, Cardiologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The prior use of sildenafil citrate is required for the current condition in adult patients initiating Tracleer.

TRELSTAR

Affected Drugs

TRELSTAR®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients who are or may become pregnant.

Required Medical Information

Diagnosis of advanced prostate cancer. Baseline electrolytes (e.g., potassium, magnesium, etc.), serum testosterone and ECG.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TREMFYA

Affected Drugs

TREMFYA

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with biologic DMARDs (e.g., TNF Antagonists)

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Dermatologist, Rheumatologist, Gastroenterologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with plaque psoriasis, the use of at least one systemic therapy (e.g., methotrexate, cyclosporine, acitretin, etc.) is required prior to the initiation of Tremfya if a patient is a candidate for systemic therapy. In patients with moderately to severely active ulcerative colitis, the use of at least one conventional therapy agent (e.g., a corticosteroid, azathioprine, or 6-mercaptopurine, etc.) is required prior to the initiation of Tremfya. For the indications listed above, the use of at least one prerequisite drug is not required in patients who have already tried a biologic. In patients with Psoriatic Arthritis or Crohn’s disease, the use of a pre-requisite drug is not required prior to the initiation of Tremfya.

TRETINOIN TOPICAL

Affected Drugs

TRETINOIN

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Cosmetic use.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved through the remainder of the contract year.

Other Criteria

N/A

TRUQAP

Affected Drugs

TRUQAP™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of strong (e.g. rifampicin, etc.) and moderate (e.g., efavirenz, etc.) CYP3A inducers.

Required Medical Information

Diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer with one or more PIK3CA/AKT1/PTEN-alterations as detected by an FDA-approved test (e.g., FoundationOne CDx, etc.), after progression on at least one endocrine-based regimen in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy. Truqap will be used in combination with fulvestrant.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TUKYSA

Affected Drugs

TUKYSA™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong CYP3A inducers (e.g., rifampin, carbamazepine, phenytoin, etc.) or moderate CYP2C8 inducers (e.g. rifampin, etc.).

Required Medical Information

In combination with trastuzumab or capecitabine for a diagnosis of advanced unresectable or metastatic HER2-positive breast cancer, including patients with brain metastases, who have received at least one prior anti-HER2-based regimens in the metastatic setting OR 2) In combination with trastuzumab for a diagnosis of RAS wild-type, HER2-positive unresectable or metastatic colorectal cancer that has progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist, Gastroenterologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TURALIO

Affected Drugs

TURALIO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and not amenable to improvement with surgery. Baseline LFT (e.g., ALT, AST, bilirubin, etc.).

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

TYMLOS

Affected Drugs

TYMLOS™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Patients that have an increased baseline risk for osteosarcoma (e.g., those with Paget's disease of bone or unexplained elevations of alkaline phosphatase, open epiphyses, bone metastases or skeletal malignancies, hereditary disorders predisposing to osteosarcoma, or prior external beam or implant radiation therapy involving the skeleton), or underlying hypercalcemic disorder (e.g., primary hyperparathyroidism). Use of Tymlos and parathyroid hormone analogs (e.g. Forteo, etc.) for more than 2 years.

Required Medical Information

History of one of the following: 1. The patient is at high risk for fractures (BMD T score below -2.5, steroids use) or has a history of an osteoporotic fracture. 2. The patient had a fracture and/ or experienced a decrease in BMD T score while on either alendronate, risedronate, and ibandronate. 3. The patient is not a candidate for bisphosphonates or intolerant to them.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for 2 years.

Other Criteria

N/A

UBRELVY

Affected Drugs

UBREVELY®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one generic triptan therapy (e.g., sumatriptan, zolmitriptan, naratriptan, rizatriptan, etc.) is required prior to initiation of Ubrelvy unless contraindicated or the member has had an inadequate response to triptan therapy.

UDENYCA

Affected Drugs

UDENYCA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Baseline CBC and platelet count.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist or Infectious Disease Specialist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

UPTRAVI

Affected Drugs

UPTRAVI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Severe hepatic impairment (Child-Pugh Class C).

Required Medical Information

Diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1).

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist, Cardiologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

VALCHLOR

Affected Drugs

VALCHLOR®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Dermatologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

At least one prior skin-directed therapy (e.g., bexarotene, methotrexate, etc.) is required for the treatment of the current condition prior to initiation of Valchlor.

VALTOCO

Affected Drugs

VALTOCO®

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Acute narrow-angle glaucoma.

Required Medical Information

N/A

Age Restrictions

Approve if 2 years of age or older and under age 65. If aged 65 years and older, other criteria will apply.

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

A clinical justification indicating that the benefit of Valtoco outweighs the potential risks will be required in members 65 years of age and older.

VANFLYTA

Affected Drugs

VANFLYTA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Severe hypokalemia. Severe hypomagnesemia. Long QT syndrome. History of ventricular arrhythmias or torsades de pointes.

Required Medical Information

Diagnosis of newly diagnosed acute myeloid leukemia (AML) that is FLT3 internal tandem duplication (ITD)-positive as detected by an FDA-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay, etc.), to be used 1) in combination with standard cytarabine and anthracycline induction or cytarabine consolidation or 2) as maintenance monotherapy following consolidation chemotherapy. Baseline ECG, potassium, magnesium.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

VENCLEXTA

Affected Drugs

VENCLEXTA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with strong CYP3A4 inhibitors (e.g., ketoconazole, conivaptan, clarithromycin, indinavir, itraconazole, lopinavir, ritonavir, telaprevir, posaconazole, voriconazole, etc.) at initiation and during ramp-up phase.

Required Medical Information

Diagnosis of 1) chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) or 2) in combination with azacitidine or decitabine or low-dose cytarabine, newly-diagnosed acute myeloid leukemia (AML) in adults who are age 75 years or older, or who have comorbidities that preclude use of intensive induction chemotherapy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

VERQUVO

Affected Drugs

VERQUVO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with other soluble guanylate cyclase (sGC) stimulators. Concomitant use with PDE-5 Inhibitors. Pregnancy in females of reproductive potential.

Required Medical Information

Diagnosis of symptomatic chronic heart failure in patients with ejection fraction less than 45%.

Age Restrictions

N/A

Prescriber Restrictions

Cardiologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least of two other medications for heart failure (e.g., ACEI, ARB, beta-blocker, Entresto, aldosterone antagonist, diuretic, Corlanor, Farxiga, Jardiance, etc.) is required prior to the initiation of Verquvo.

VERZENIO

Affected Drugs

VERZENIO™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of Verzenio with strong CYP3A inducers (e.g., rifampin, carbamazepine, phenytoin, etc.) or ketoconazole.

Required Medical Information

Diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node-positive, early breast cancer at high risk of recurrence: Verzenio will be used in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) for the adjuvant treatment or Diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer: Verzenio will be used (1) in combination with fulvestrant in adults with disease progression following endocrine therapy OR (2) as monotherapy in adults with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting OR (3) in combination with an aromatase inhibitor as initial endocrine-based therapy in adults. Baseline LFTs, CBC.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

VITRAKVI

Affected Drugs

VITRAKVI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with sensitive CYP3A4 substrates (e.g., midazolam, triazolam, etc.).

Required Medical Information

Diagnosis of solid tumor that 1) have a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation, 2) are metastatic or where surgical resection is likely to result in severe morbidity, AND 3) have no satisfactory alternative treatments or that have progressed following treatment.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

VIZIMPRO

Affected Drugs

VIZIMPRO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Interstitial Lung Disease

Required Medical Information

Diagnosis of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test (e.g., cobas EGFR Mutation Test v2, FoundationOne CDx, etc.).

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

VONJO

Affected Drugs

VONJO™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of strong CYP3A4 inhibitors (i.e., clarithromycin, etc.) or inducers (i.e., rifampin, etc.). Active bleeding. Baseline QTc greater than 480 msec. Baseline eGFR less than 30mL/min. Moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment.

Required Medical Information

Diagnosis of intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis with a platelet count below 50 x 109/L. Baseline CBC and QTc.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

VORANIGO

Affected Drugs

VORANIGO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with moderate CYP1A2 inducers (e.g., phenytoin, rifampicin, etc.).

Required Medical Information

Grade 2 astrocytoma or oligodendroglioma with a susceptible IDH1 or IDH2 mutation, following surgery including biopsy, sub-total resection, or gross total resection. Baseline LFTs.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Neurologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

VORICONAZOLE INJ

Affected Drugs

VORICONAZOLE INJECTION

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for 6 months.

Other Criteria

The requested drug will be used intravenously.

VOSEVI

Affected Drugs

VOSEVI®

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use of rifampin, amiodarone, P-gp inducers, or moderate to potent CYP2B6, CYP2C8, or CYP3A4 inducers (e.g., carbamazepine).

Required Medical Information

Diagnosis of chronic HCV infection without cirrhosis or with compensated cirrhosis (Child-Pugh A) with: 1) genotype 1, 2, 3, 4, 5, or 6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor (e.g., Harvoni, Epclusa, ledipasvir-sofosbuvir, sofosbuvir-velpatasvir, etc.) or 2) genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor. Criteria will be applied consistent with current AASLD IDSA guidance.

Age Restrictions

N/A

Prescriber Restrictions

Infectious Disease Specialist, Gastroenterologist, Hepatologist

Coverage Duration

The PA will be approved consistent with current AASLD IDSA guidance.

Other Criteria

Criteria will be applied consistent with current AASLD IDSA guidance

VOWST

Affected Drugs

VOWST™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Treatment of Clostridioides difficile infection (CDI).

Required Medical Information

In patients with recurrent CDI (rCDI), Vowst will be used to prevent CDI recurrence following antibacterial treatment.

Age Restrictions

Approve if 18 years old or older.

Prescriber Restrictions

Infectious Disease Specialist

Coverage Duration

The PA will be approved for 3 months.

Other Criteria

Initiation: the use of at least two formulary therapies (e.g., oral vancomycin, oral metronidazole, Dificid, etc.) is required prior to the initiation of Vowst. If the patient has previously received Vowst: 1) treatment failure (defined as the presence of CDI diarrhea within 8 weeks of first dose of Vowst and a positive stool test for CDI) of Vowst, and 2) the patient has not received more than one treatment course of Vowst which was at least 12 days and not more than 8 weeks prior.

VUMERITY

Affected Drugs

VUMERITY™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) relapsing forms of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and 2) active secondary progressive disease. Recent (e.g., within six months) complete blood count (CBC).

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

WELIREG

Affected Drugs

WELIREG™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) von Hippel-Lindau (VHL) disease in patients who require therapy for associated renal cell carcinoma (RCC), central nervous system (CNS) hemangioblastomas, or pancreatic neuroendocrine tumors (pNET), not requiring immediate surgery or 2) advanced renal cell carcinoma following a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) or 3) locally advanced, unresectable, or metastatic pheochromocytoma or paraganglioma (PPGL).

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Endocrinologist, Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

XALKORI

Affected Drugs

XALKORI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with congenital long QT syndrome. In a patient restarting Xalkori, the patient has experienced 1) QTc greater than 500 ms or greater than or equal to 60 ms change from baseline with Torsade de pointes or polymorphic ventricular tachycardia or signs/symptoms of serious arrhythmia and 2) ALT or AST elevation greater than 3 times ULN with concurrent total bilirubin elevation greater than 1.5 times ULN (in the absence of cholestasis or hemolysis) and 3) any Grade drug-related interstitial lung disease/pneumonitis with the previous Xalkori treatment.

Required Medical Information

Diagnosis of 1) Anaplastic Lymphoma Kinase (ALK)-positive or ROS1-positive metastatic Non-Small Cell Lung Cancer (NSCLC) detected by an FDA approved test, 2) Anaplastic Lymphoma Kinase (ALK)-positive relapsed or refractory systemic anaplastic large cell lymphoma (ALCL), or 3) ALK-positive unresectable, recurrent, or refractory inflammatory myofibroblastic tumor (IMT). Baseline CBC with differential and liver function tests including ALT and total bilirubin.

Age Restrictions

ALCL: Approve if 1 year of age and older and young adults (e.g., 1 to 21 y.o.). IMT: Approve if 1 year of age and older. All others: none

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

XCOPRI

Affected Drugs

XCOPRI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Familial Short QT syndrome. End stage renal disease (ESRD) (Creatinine clearance less than 15 mL/min) requiring dialysis. Severe hepatic impairment (Child-Pugh C).

Required Medical Information

N/A

Age Restrictions

Approve if 18 years old or older.

Prescriber Restrictions

Neurologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one formulary anticonvulsant (e.g., valproic acid, topiramate, etc.) for the current condition is required prior to initiation of Xcopri.

XDEMVY

Affected Drugs

XDEMVY®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of Demodex blepharitis.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for 6 months.

Other Criteria

N/A

XELJANZ

Affected Drugs

XELJANZ®
XELJANZ® XR

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with biologic DMARDs (e.g., TNF Antagonists) or with potent immunosuppressants, such as azathioprine or cyclosporine.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist, Gastroenterologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with Rheumatoid Arthritis, active Polyarticular Course Juvenile Idiopathic Arthritis, Psoriatic Arthritis, moderately to severely active ulcerative colitis, or Ankylosing Spondylitis, the use of at least one TNF blocker is required (unless unable to tolerate) prior to initiation of Xeljanz.

XERMELO

Affected Drugs

XERMELO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of carcinoid syndrome diarrhea in patients inadequately controlled by somatostatin analog (SSA) therapy. Xermelo will be used in combination with SSA therapy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved through the remainder of the contract year.

Other Criteria

N/A

XGEVA

Affected Drugs

XGEVA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients with pre-existing hypocalcemia

Required Medical Information

1) Giant cell tumor of bone: a diagnosis of unresectable giant cell tumor of bone or where surgical resection is likely to result in severe morbidity, or 2) prevention of skeletal related events in patients with multiple myeloma or bone metastases from solid tumors: diagnosis of a) multiple myeloma or b) solid tumors and evidence of one or more metastatic bone lesions, or 3) hypercalcemia of malignancy: persistent hypercalcemia refractory to bisphosphonate therapy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

Xgeva is not used in patients on Prolia.

XIFAXAN

Affected Drugs

XIFAXAN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) travelers diarrhea caused by Escherichia coli, 2) hepatic encephalopathy, or 3) irritable bowel syndrome with diarrhea (IBS-D).

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with travelers diarrhea, a use of ciprofloxacin, levofloxacin, or azithromycin is required prior to initiation of Xifaxan. In patients with hepatic encephalopathy, a use of lactulose is required prior to initiation of Xifaxan. In patients with IBS-D, a use of loperamide is required prior to initiation of Xifaxan.

XOLAIR

Affected Drugs

XOLAIR®

Covered Uses

All Medically-accepted Indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

In patients with moderate to severe persistent asthma 1) a positive skin test or in vitro reactivity to a perennial aeroallergen (e.g., house dust mite, animal dander, mold spores, etc.) and 2) baseline serum IgE greater than or equal to 30 IU/mL. In patients with seasonal or perennial allergic rhinitis, a positive skin test or in vitro for one or more relevant allergens (e.g., grass, tree, or weed pollen, mold spores, house dust mite, etc.).

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with moderate to severe persistent asthma, the use of at least one formulary inhaled corticosteroid (e.g., fluticasone-salmeterol diskus, mometasone-formoterol, etc.) is required prior to the initiation of Xolair. In patients with chronic idiopathic urticaria, seasonal allergic rhinitis, or perennial allergic rhinitis, the use of at least one formulary H1 antihistamine (e.g., levocetirizine, desloratadine, etc.) is required prior to the initiation of Xolair. In patients with nasal polyps, the use of at least one formulary nasal corticosteroid (e.g., mometasone, etc.) is required prior to the initiation of Xolair. In patients with immunotherapy-related toxicities, the use of at least one

conventional therapy (e.g., levocetirizine, desloratadine, prednisone, methylprednisolone etc.) or aprepitant is required prior to the initiation of Xolair. In patients with systemic mastocytosis, the use of at least one conventional therapy (e.g., levocetirizine, desloratadine, prednisone, etc.) is required prior to the initiation of Xolair. In patients with IgE-mediated food allergy, the use of prerequisite drugs is not required.

XOSPATA

Affected Drugs

XOSPATA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with P-gp and strong CYP3A inducers (e.g., phenytoin, rifampin, carbamazepine, etc.), or strong CYP3A inhibitors (e.g., ketoconazole, clarithromycin, voriconazole, etc.). Patients with prolonged QT interval (e.g., QTcF greater than 500 msec, etc.).

Required Medical Information

Diagnosis of relapsed or refractory acute myeloid leukemia (AML) with a FLT3 mutation as detected by an FDA-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay, etc.). Baseline potassium and magnesium.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

XPOVIO

Affected Drugs

XPOVIO

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of 1) multiple myeloma, Xpovio will be used in combination with dexamethasone and bortezomib, after receiving at least one prior therapy or 2) relapsed or refractory multiple myeloma, Xpovio will be used in combination with dexamethasone or 3) relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma, after receiving at least two prior lines of systemic therapy. Baseline neutrophil count and sodium level.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

XTANDI

Affected Drugs

XTANDI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In women who are or may become pregnant

Required Medical Information

Diagnosis of 1) castration-resistant prostate cancer or 2) metastatic castration-sensitive prostate cancer or 3) non-metastatic castration-sensitive prostate cancer. For patients with castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer, concurrent use of Xtandi with a gonadotropin-releasing hormone (GnRH) analog is required unless the patient has had a bilateral orchiectomy.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Urologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

XYWAV

Affected Drugs

XYWAV®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

In patients being treated with sedative hypnotic agents (e.g., zolpidem, mirtazapine, etc.) or diagnosis of succinic semialdehyde dehydrogenase deficiency.

Required Medical Information

Diagnosis of 1) cataplexy in narcolepsy or 2) excessive daytime sleepiness in narcolepsy or 3) idiopathic hypersomnia.

Age Restrictions

N/A

Prescriber Restrictions

Sleep Specialist or Neurologist

Coverage Duration

The PA will be approved through the remainder of the contract year.

Other Criteria

In patients with narcolepsy, a trial of one formulary CNS stimulant (e.g., methylphenidate, dextroamphetamine, modafinil, etc.) is required prior to initiation of Xywav (a trial of a CNS stimulant is not required if a patient with narcolepsy has a history of stimulant drug abuse and dependence or other contraindications to a CNS stimulant).

YONSA

Affected Drugs

YONSA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pregnancy in females of reproductive potential. Severe hepatic impairment (Child-Pugh Class C). NYHA Class III or IV heart failure. LVEF is less than 50%.

Required Medical Information

Yonsa is administered in combination with methylprednisolone. AST and ALT less than or equal to 2.5X ULN and total bilirubin less than or equal to 1.5X ULN. Serum potassium is within normal limits prior to initiation.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ZEJULA

Affected Drugs

ZEJULA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Pregnancy in females of reproductive potential. Zejula will not be initiated until patients have recovered from hematological toxicity caused by previous chemotherapy (less than or equal Grade 1).

Required Medical Information

Diagnosis of 1) deleterious or suspected deleterious germline BRCA-mutated recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients who are in a complete or partial response to platinum-based chemotherapy or 2) advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to first-line platinum-based chemotherapy. Baseline CBC.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Gynecologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of Lynparza is required prior to the initiation of Zejula.

ZELBORAF

Affected Drugs

ZELBORAF®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Wild-type BRAF melanoma. Uncorrectable electrolyte abnormalities and long QT syndrome.

Required Medical Information

Diagnosis of 1) unresectable or metastatic melanoma with BRAFV600E mutation confirmed by an FDA-approved test (e.g., cobas 4800 BRAF V600 Mutation Test, etc.) or 2) Erdheim-Chester Disease with BRAF V600 mutation. In patients who are taking medications known to prolong the QT interval, discontinuation of these medications is required with initiation of Zelboraf. Baseline ECG and electrolytes, including potassium, magnesium, and calcium, dermatologic evaluation, liver enzymes (transaminases and alkaline phosphatase) and bilirubin. QTc interval is less than or equal to 500ms. In a patient restarting Zelboraf, the patient hasn't experienced Common Terminology Criteria for Adverse Events v4.0 (CTC-AE) Grade 2 (Intolerable) or Grade 3: 3rd appearance and Grade 4: 2nd appearance with the previous Zelboraf treatment.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A

ZOLINZA

Affected Drugs

ZOLINZA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

The use of at least one systemic therapy for the current condition: bexarotene oral or CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or interferon alfa-2b or methotrexate is required prior to the initiation of Zolinza.

ZURZUVAE

Affected Drugs

ZURZUVAE™

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

Concomitant use with CYP3A4 inducers (e.g., rifampin, etc.).

Required Medical Information

Diagnosis of postpartum depression.

Age Restrictions

N/A

Prescriber Restrictions

Obstetrician-Gynecologist, Psychiatrist

Coverage Duration

The PA will be approved for 14 days

Other Criteria

Onset of symptoms in the third trimester or within 4 weeks of delivery. Patient is less than or equal to 12 months postpartum.

ZYDELIG

Affected Drugs

ZYDELIG®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

History of serious allergic reactions, including anaphylaxis and toxic epidermal necrolysis. In patients with life-threatening diarrhea, intestinal perforation, or symptomatic pneumonitis.

Required Medical Information

CBC and liver function tests: ALT, AST, bilirubin.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

In patients with relapsed chronic lymphocytic leukemia (CLL), Zydelig is used in combination with rituximab (for whom rituximab alone would be considered appropriate therapy due to other co-morbidities).

ZYKADIA

Affected Drugs

ZYKADIA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Off-label Uses

N/A

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of Anaplastic Lymphoma Kinase (ALK)-positive metastatic Non-Small Cell Lung Cancer. Baseline ECG and liver function tests including ALT and total bilirubin. In a patient restarting Zykadia, the patient hasn't experienced 1) ALT or AST elevation greater than 3 times ULN with concurrent total bilirubin elevation greater than 2 times ULN (in the absence of cholestasis or hemolysis) and 2) any Grade treatment-related interstitial lung disease/pneumonitis and 3) QTc interval prolongation with Torsade de pointes or polymorphic ventricular tachycardia or signs/symptoms of serious arrhythmia and 4) life-threatening bradycardia if no contributing concomitant medication with the previous Zykadia treatment.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

The PA will be approved for lifetime.

Other Criteria

N/A