

ABALOPARATIDE

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	PATIENT HAS RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT WITH ANY PARATHYROID HORMONE THERAPY.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS). NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES.
Indications	All FDA-approved Indications.
Off Label Uses	

ABATACEPT IV

Products Affected

- ORENCIA (WITH MALTOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. RENEWAL: RA, PJIA, PSA: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

ABATACEPT SQ

Products Affected

- ORENCIA
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. RENEWAL: RA, PJIA, PSA: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

ABEMACICLIB

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ABIRATERONE

Products Affected

- ZYTIGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ABIRATERONE SUBMICRONIZED

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO THE FORMULARY PREFERRED AGENT ZYTIGA (ABIRATERONE ACETATE).
Indications	All FDA-approved Indications.
Off Label Uses	

ACALABRUTINIB

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ADALIMUMAB

Products Affected

- HUMIRA
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST 3 MONTHS OF TREATMENT WITH AT LEAST ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD.

PA Criteria	Criteria Details
	<p>ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AN NSAID. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY. CROHNS DISEASE (CD) AND ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY. RENEWAL FOR RA, PJIA, PSA, AS, PSO, HIDRADENITIS SUPPURATIVA, OR UVEITIS: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.</p>
Indications	All FDA-approved Indications.
Off Label Uses	

AFATINIB DIMALEATE

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AGALSIDASE BETA

Products Affected

- FABRAZYME

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FABRY DISEASE INITIAL: THE PATIENT IS NOT CONCURRENTLY USING AN ALPHA-GAL A PHARMACOLOGICAL CHAPERONE (I.E. GALAFOLD (MIGALASTAT)). THE PATIENT IS SYMPTOMATIC OR HAS EVIDENCE OF INJURY FROM GL-3 TO THE KIDNEY, HEART, OR CENTRAL NERVOUS SYSTEM RECOGNIZED BY LABORATORY, HISTOLOGICAL, OR IMAGING FINDINGS.
Age Restrictions	8 YEARS OF AGE OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH NEPHROLOGIST, CARDIOLOGIST, OR SPECIALIST IN GENETICS OR INHERITED METABOLIC DISORDERS.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	FABRY DISEASE RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED IMPROVEMENT OR STABILIZATION.
Indications	All FDA-approved Indications.
Off Label Uses	

ALECTINIB

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ALEMTUZUMAB - LEMTRADA

Products Affected

- LEMTRADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL: AT LEAST 12 MONTHS HAVE ELAPSED SINCE THE PATIENT RECEIVED THE MOST RECENT COURSE OF LEMTRADA.
Indications	All FDA-approved Indications.
Off Label Uses	

ALIROCUMAB

Products Affected

- PRALUENT PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. MEETS ONE OF THE FOLLOWING: (1) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), (4) STATIN INTOLERANCE, OR (5) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY). RENEWAL: PATIENT MEETS ONE OF THE FOLLOWING: 1) CONTINUED CONCURRENT THERAPY WITH A MAXIMALLY TOLERATED DOSE OF A STATIN, 2) STATIN INTOLERANCE, OR 3) A CONTRAINDICATION TO STATIN THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

ALPELISIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AMANTADINE

Products Affected

- GOCOVRI ORAL
CAPSULE,EXTENDED RELEASE
24HR 137 MG, 68.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ANAKINRA

Products Affected

- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, RINVOQ, ENBREL, XELJANZ. RENEWAL: RA: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

APALUTAMIDE

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: NON METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NMCRPC OR METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): PATIENT MEETS ONE OF THE FOLLOWING: (1) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST OR ANTAGONIST OR (2) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY. RENEWAL: A DIAGNOSIS OF NMCRPC OR MCSPC.
Indications	All FDA-approved Indications.
Off Label Uses	

APOMORPHINE - SL

Products Affected

- KYNMOBI SUBLINGUAL FILM 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	PARKINSONS DISEASE (PD): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PD: PHYSICIAN HAS OPTIMIZED DRUG THERAPY FOR PARKINSONS DISEASE. RENEWAL: PD: PATIENT IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF KYNMOBI.
Indications	All FDA-approved Indications.
Off Label Uses	

APOMORPHINE HCL

Products Affected

- APOKYN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF PATIENT IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF APOKYN.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PHYSICIAN ATTESTATION OF OPTIMIZATION OF DRUG THERAPY FOR PARKINSON'S DISEASE.
Indications	All FDA-approved Indications.
Off Label Uses	

APREMILAST

Products Affected

- OTEZLA
- OTEZLA STARTER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. BEHCETS DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. BEHCETS DISEASE: 1) PATIENT HAS ORAL ULCERS OR A HISTORY OF RECURRENT ORAL ULCERS BASED ON CLINICAL SYMPTOMS AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OR MORE CONSERVATIVE TREATMENTS. RENEWAL: PSA, PSO, BEHCETS DISEASE: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

ASFOTASE

Products Affected

- STRENSIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION, SERUM ALKALINE PHOSPHATASE (ALP) LEVEL, SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS, URINE PHOSPHOETHANOLAMINE (PEA) LEVEL, RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP)
Age Restrictions	PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP): 6 MONTHS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET. JUVENILE-ONSET HYPOPHOSPHATASIA (HPP): 18 YEARS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET.
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST, A GENETICIST, OR A METABOLIC SPECIALIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: FOR PATIENTS WITH PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.) RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.) PRESENCE OF TWO OR MORE OF THE

PA Criteria	Criteria Details
	<p>FOLLOWING: RACHITIC CHEST DEFORMITY, CRANIOSYNOSTOSIS (PREMATURE CLOSURE OF SKULL BONES), DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, NEPHROCALCINOSIS, OR HISTORY OF ELEVATED SERUM CALCIUM. HISTORY OR PRESENCE OF NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. FOR PATIENTS WITH JUVENILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.)URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.)RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, OSTEOMALACIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.)PRESENCE OF TWO OR MORE OF THE FOLLOWING:RACHITIC DEFORMITIES (RACHITIC CHEST, BOWED LEGS, KNOCK-KNEES),PREMATURE LOSS OF PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, OR HISTORY OR PRESENCE OF NON-TRAUMATIC FRACTURES OR DELAYED FRACTURE HEALING. STRENSIQ WILL NOT BE APPROVED FOR THE FOLLOWING PATIENTS: PATIENTS CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE [E.G., BONIVA (IBANDRONATE), FOSAMAX (ALENDRONATE), ACTONEL (RISEDRONATE)], PATIENTS WITH SERUM CALCIUM OR PHOSPHATE LEVELS BELOW THE NORMAL RANGE, PATIENTS WITH A TREATABLE FORM OF RICKETS. RENEWAL: PATIENT HAS EXPERIENCED AN IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HYPOPHOSPHATASIA (HPP) (E.G., IMPROVEMENT OF THE IRREGULARITY OF THE PROVISIONAL ZONE OF CALCIFICATION, PHYSEAL WIDENING, METAPHYSEAL FLARING, RADIOLUCENCIES, PATCHY OSTEOSCLEROSIS, RATIO OF MID-DIAPHYSEAL CORTEX TO BONE THICKNESS, GRACILE BONES, BONE FORMATION AND FRACTURES.</p>

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

ASPARAGINASE

Products Affected

- ONCASPAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ATEZOLIZUMAB

Products Affected

- TECENTRIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AVAPRITINIB

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AVATROMBOPAG

Products Affected

- DOPTELET (10 TAB PACK)
- DOPTELET (15 TAB PACK)
- DOPTELET (30 TAB PACK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>CHRONIC LIVER DISEASE (CLD): PATIENT HAS A PLANNED PROCEDURE 10 TO 13 DAYS AFTER INITIATION OF DOPTELET. PATIENT IS NOT RECEIVING OTHER THROMBOPOIETIN RECEPTOR AGONISTS (E.G. ROMIPLOSTIM, ELTROMBOPAG, ETC.). CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS OR IMMUNOGLOBULINS OR INSUFFICIENT RESPONSE TO SPLENECTOMY, RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.</p>
Age Restrictions	
Prescriber Restrictions	<p>CLD: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, GASTROENTEROLOGIST, HEPATOLOGIST, IMMUNOLOGIST, OR ENDOCRINOLOGIST. CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.</p>
Coverage Duration	<p>CLD: 1 MONTH. CHRONIC ITP: INITIAL: 2 MONTHS, RENEWAL: 12 MONTHS.</p>
Other Criteria	
Indications	<p>All FDA-approved Indications.</p>
Off Label Uses	

AVELUMAB

Products Affected

- BAVENCIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AZACITIDINE

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AZTREONAM LYSINE

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	AT LEAST 7 YEARS OLD
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BARICITINIB

Products Affected

- OLUMIANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL FOR RA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. RENEWAL FOR RA: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

BECAPLERMIN

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Exclusion Criteria	NON-DIABETIC ULCERS, NEOPLASM AT APPLICATION SITE, PRESSURE OR VENOUS STASIS ULCERS AND ULCERS THAT DO NOT EXTEND THROUGH THE DERMIS.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST, PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	3 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BEDAQUILINE FUMARATE

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 WEEKS
Other Criteria	SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR THE TREATMENT OF PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS.
Indications	All FDA-approved Indications.
Off Label Uses	

BELANTAMAB MAFODOTIN-BLMF

Products Affected

- BLENREP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BELIMUMAB

Products Affected

- BENLYSTA INTRAVENOUS
- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AUTOANTIBODY POSITIVE LUPUS TEST.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEMBER IS CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. NO APPROVAL FOR DIAGNOSIS OF SEVERE ACTIVE LUPUS NEPHRITIS, SEVERE CENTRAL NERVOUS SYSTEM LUPUS OR CONCURRENT USE OF BIOLOGIC AGENTS OR INTRAVENOUS CYCLOPHOSPHAMIDE. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

BELINOSTAT

Products Affected

- BELEODAQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BEMPEDOIC ACID

Products Affected

- NEXLETOL
- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL FOR HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA: TRIAL OF OR CONTRAINDICATION TO EZETIMIBE. ALL INDICATIONS: INITIAL: MEETS ONE OF THE FOLLOWING: (1) TRIAL OF A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY), (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTION), (4) STATIN INTOLERANCE, OR (5) SKELETAL-MUSCLE EVENTS WHILE ON STATIN THERAPY. RENEWAL: MEETS ONE OF THE FOLLOWING: (1) LDL-C LOWERING AND CONTINUED THERAPY WITH A MAXIMALLY TOLERATED DOSE OF ANY STATIN, (2) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY, OR (3) COMPLETE STATIN INTOLERANCE.
Indications	All FDA-approved Indications.
Off Label Uses	

BENDAMUSTINE

Products Affected

- BENDEKA
- TREANDA INTRAVENOUS RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BENRALIZUMAB

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: CONCURRENT USE OF XOLAIR, DUPIXENT, OR OTHER ANTI-IL5 BIOLOGICS
Required Medical Information	INITIAL: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: 1) PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION AND 2) PATIENT HAS EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS). RENEWAL: PATIENT HAS SHOWN A CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR 4) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	

BEVACIZUMAB

Products Affected

- AVASTIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BEVACIZUMAB-AWWB

Products Affected

- MVASI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BEVACIZUMAB-BVZR

Products Affected

- ZIRABEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BEXAROTENE

Products Affected

- *bexarotene*
- TARGRETIN TOPICAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BINIMETINIB

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BLINATUMOMAB

Products Affected

- BLINCYTO INTRAVENOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: RELAPSED OR REFRACTORY B-CELL: 3 MOS. MRD-POSITIVE B-CELL: 2 MOS. RENEWAL: 12 MOS.
Other Criteria	INITIAL: RELAPSED OR REFRACTORY B-CELL PRECURSOR ALL: APPROVAL IS FOR 2 CYCLES, MAY APPROVE FOR 1 ADDITIONAL CYCLE DUE TO TREATMENT INTERRUPTION FOR DOSE MODIFICATION. RENEWAL: FOR DIAGNOSIS OF RELAPSED OR REFRACTORY B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED COMPLETE REMISSION (CR) OR CR WITH PARTIAL HEMATOLOGICAL RECOVERY OF PERIPHERAL BLOOD COUNTS AFTER 2 CYCLES OF TREATMENT. RENEWAL IS NOT APPROVED FOR PATIENTS WHO RECEIVED AN ALLOGENEIC HEMATOPOIETIC STEM-CELL TRANSPLANT. FOR DIAGNOSIS OF MINIMAL RESIDUAL DISEASE (MRD)-POSITIVE B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED UNDETECTABLE MINIMAL RESIDUAL DISEASE (MRD) WITHIN ONE CYCLE OF BLINCYTO TREATMENT AND IS RELAPSE-FREE (I.E., HEMATOLOGICAL OR EXTRAMEDULLARY RELAPSE, OR SECONDARY LEUKEMIA). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

BORTEZOMIB

Products Affected

- BORTEZOMIB
- VELCADE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BOSUTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CHRONIC, ACCELERATED, OR BLAST PHASE PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOGENOUS LEUKEMIA: BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT T315I, V299L, G250E, OR F317L MUTATIONS ARE NOT PRESENT.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BRENTUXIMAB

Products Affected

- ADCETRIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BRIGATINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BRODALUMAB

Products Affected

- SILIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. PATIENT HAS BEEN COUNSELED ON AND EXPRESSES UNDERSTANDING OF THE RISK OF SUICIDAL IDEATION AND BEHAVIOR. RENEWAL: PSO: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION AND HAS NOT DEVELOPED OR REPORTED WORSENING DEPRESSIVE SYMPTOMS OR SUICIDAL IDEATION AND BEHAVIORS WHILE ON TREATMENT WITH SILIQ.
Indications	All FDA-approved Indications.
Off Label Uses	

C1 ESTERASE INHIBITOR-CINRYZE, BERINERT

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CINRYZE RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY) IN HAE ATTACKS WITH ROUTINE PROPHYLAXIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

C1 ESTERASE INHIBITOR-HAEGARDA, RUCONEST

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HAEGARDA RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY) IN HAE ATTACKS WITH ROUTINE PROPHYLAXIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING.
Indications	All FDA-approved Indications.
Off Label Uses	

CABOZANTINIB

Products Affected

- COMETRIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CABOZANTINIB S-MALATE - CABOMETYX

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CANAKINUMAB

Products Affected

- ILARIS (PF) SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR AN IMMUNOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CANNABIDIOL

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	LENNOX-GASTAUT SYNDROME (LGS): TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: CLOBAZAM, TOPIRAMATE, LAMOTRIGINE.
Indications	All FDA-approved Indications.
Off Label Uses	

CAPLACIZUMAB YHDP

Products Affected

- CABLIVI INJECTION KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	2 MONTHS
Other Criteria	CABLIVI WAS PREVIOUSLY INITIATED AS PART OF THE FDA APPROVED TREATMENT REGIMEN IN COMBINATION WITH PLASMA EXCHANGE AND IMMUNOSUPPRESSIVE THERAPY WITHIN AN INPATIENT SETTING. THE PATIENT HAS NOT EXPERIENCED MORE THAN TWO RECURRENCES OF ATTP WHILE ON CABLIVI THERAPY (I.E., NEW DROP IN PLATELET COUNT REQUIRING REPEAT PLASMA EXCHANGE DURING 30 DAYS POST-PLASMA EXCHANGE THERAPY [PEX] AND UP TO 28 DAYS OF EXTENDED THERAPY).
Indications	All FDA-approved Indications.
Off Label Uses	

CAPMATINIB

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CARFILZOMIB

Products Affected

- KYPROLIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CEMIPLIMAB

Products Affected

- LIBTAYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CERITINIB

Products Affected

- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CERTOLIZUMAB PEGOL

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PATIENT HAS ONE OF THE FOLLOWING OBJECTIVE SIGNS OF INFLAMMATION: 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS/ANKYLOSING SPONDYLITIS/NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHNS DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSORIATIC ARTHRITIS (PSA) PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS

PA Criteria	Criteria Details
	TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHNS DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA. PATIENTS WHO ARE PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT ARE EXCLUDED FROM STEP CRITERIA FOR ALL INDICATIONS. RENEWAL FOR RA, PSA, AS, PSO OR NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

CLADRIBINE

Products Affected

- MAVENCLAD (10 TABLET PACK)
- MAVENCLAD (4 TABLET PACK)
- MAVENCLAD (5 TABLET PACK)
- MAVENCLAD (6 TABLET PACK)
- MAVENCLAD (7 TABLET PACK)
- MAVENCLAD (8 TABLET PACK)
- MAVENCLAD (9 TABLET PACK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE TREATMENT BASELINE AND THE PATIENT DOES NOT HAVE LYMPHOPENIA.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	48 WEEKS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CLOBAZAM

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO LAMOTRIGINE OR TOPIRAMATE. REQUESTS FOR ORAL SUSPENSION APPROVABLE IF PATIENT IS UNABLE TO SWALLOW OR IS UNDER THE AGE OF 5 YEARS.
Indications	All FDA-approved Indications.
Off Label Uses	

CLOBAZAM-SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PHYSICIAN ATTESTATION THAT THE PATIENT IS UNABLE TO TAKE TABLETS OR SUSPENSION. TRIAL OF OR CONTRAINDICATION TO A FORMULARY CLOBAZAM AGENT.
Indications	All FDA-approved Indications.
Off Label Uses	

COBIMETINIB FUMARATE

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

COLCHICINE

Products Affected

- *colchicine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PROPHYLAXIS OF GOUT FLARES: 16 YEARS AND OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO COLCHICINE CAPSULES (MITIGARE) WHERE INDICATIONS ALIGN.
Indications	All FDA-approved Indications.
Off Label Uses	

COPANLISIB DI-HCL

Products Affected

- ALIQOPA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CORTICOTROPIN

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	NOT APPROVED FOR DIAGNOSTIC PURPOSES.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS (MS): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, ALLERGIST/IMMUNOLOGIST, OPHTHALMOLOGIST, PULMONOLOGIST OR NEPHROLOGIST.
Coverage Duration	INFANTILE SPASMS AND MS: 28 DAYS. OTHER FDA APPROVED INDICATIONS: INITIAL AND RENEWAL: 28 DAYS
Other Criteria	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS: TRIAL OF OR CONTRAINDICATION TO INTRAVENOUS (IV) CORTICOSTEROIDS. ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS: TRIAL OF OR CONTRAINDICATION TO A STANDARD OF CARE THERAPY. RENEWAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS: 1) DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS INDICATED BY SYMPTOM RESOLUTION AND/OR NORMALIZATION OF LABORATORY TESTS, AND 2) CONTINUES TO POSSESS CONTRAINDICATION TO IV CORTICOSTEROIDS.
Indications	All FDA-approved Indications.
Off Label Uses	

CRIZANLIZUMAB-TMCA

Products Affected

- ADAKVEO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SICKLE CELL DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME
Other Criteria	SICKLE CELL DISEASE: INITIAL CRITERIA FOR ADULTS (18 YEARS OR OLDER): PATIENT HAS ONE OF THE FOLLOWING: (1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR, (2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING, OR (3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME (ACS). INITIAL REQUESTS FOR PATIENTS BETWEEN THE AGES OF 16 TO 17 YEARS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA. RENEWAL FOR ALL PATIENTS: MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL DISEASE.
Indications	All FDA-approved Indications.
Off Label Uses	

CRIZOTINIB

Products Affected

- XALKORI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DABRAFENIB MESYLATE

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DACOMITINIB

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DALFAMPRIDINE

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA.
Age Restrictions	
Prescriber Restrictions	NEUROLOGIST
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT IN WALKING ABILITY.
Indications	All FDA-approved Indications.
Off Label Uses	

DARATUMUMAB

Products Affected

- DARZALEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DARATUMUMAB-HYALURONIDASE-FIHJ

Products Affected

- DARZALEX FASPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DAROLUTAMIDE

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: NON METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS) AND MEETS ONE OF THE FOLLOWING: (1) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST OR ANTAGONIST OR (2) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY. RENEWAL: A DIAGNOSIS OF NMCRPC.
Indications	All FDA-approved Indications.
Off Label Uses	

DASATINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUSLY-TREATED CHRONIC MYELOID LEUKEMIA (CML) REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, V299L, T315A, F317L/V/I/C.
Indications	All FDA-approved Indications.
Off Label Uses	

DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DEFERASIROX

Products Affected

- *deferasirox*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT) INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) AND LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G DRY WEIGHT OR GREATER. RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR LIC OF 3 MG FE/G DRY WEIGHT OR GREATER. INITIAL FOR ALL INDICATIONS: JADENU SPRINKLE REQUIRES TRIAL OF OR CONTRAINDICATION TO A GENERIC EQUIVALENT OF EITHER EXJADE TABLET FOR ORAL SUSPENSION OR JADENU TABLET.
Indications	All FDA-approved Indications.
Off Label Uses	

DEFERIPRONE

Products Affected

- FERRIPROX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL CRITERIA: REQUIRES TRIAL OF OR CONTRAINDICATION TO A FORMULARY PREFERRED VERSION OF EXJADE, JADENU, OR DESFERAL AND ONE OF THE FOLLOWING CRITERIA 1) PATIENT IS EXPERIENCING INTOLERABLE TOXICITIES OR CLINICALLY SIGNIFICANT ADVERSE EFFECTS OR HAS A CONTRAINDICATION TO THESE THERAPIES OR 2) INADEQUATE CHELATION DEFINED BY ONE OF THE FOLLOWING: A) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 2500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR B) EVIDENCE OF CARDIAC IRON ACCUMULATION (I.E., CARDIAC T2 STAR MRI LESS THAN 10 MILLISECONDS, IRON INDUCED CARDIOMYOPATHY, FALL IN LEFT VENTRICULAR EJECTION FRACTION, ARRHYTHMIA INDICATING INADEQUATE CHELATION). RENEWAL: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS).
Indications	All FDA-approved Indications.
Off Label Uses	

DEFEROXAMINE

Products Affected

- *deferoxamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	CHRONIC IRON OVERLOAD: AT LEAST 3 YEARS OF AGE OR OLDER
Prescriber Restrictions	CHRONIC IRON OVERLOAD: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: CHRONIC IRON OVERLOAD: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). RENEWAL: CHRONIC IRON OVERLOAD: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

DEFLAZACORT

Products Affected

- EMFLAZA ORAL SUSPENSION
- EMFLAZA ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PHYSICIAN ATTESTATION OF GENETIC TESTING CONFIRMING DMD DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL CRITERIA: REQUIRE TRIAL OF PREDNISONE OR PREDNISOLONE AND PATIENT MEETS ONE OF THE FOLLOWING: 1) REQUEST DUE TO ADVERSE EFFECTS OF PREDNISONE OR PREDNISOLONE OR 2) REQUEST DUE TO LACK OF EFFICACY OF PREDNISONE OR PREDNISOLONE AND ALL OF THE FOLLOWING CRITERIA ARE MET: A) PATIENT IS NOT IN STAGE 1 (PRE-SYMPTOMATIC PHASE) B) STEROID MYOPATHY HAS BEEN RULED OUT C) PHYSICIAN ATTESTATION OF DETERIORATION IN AMBULATION, FUNCTIONAL STATUS, OR PULMONARY FUNCTION CONSISTENT WITH ADVANCING DISEASE. RENEWAL CRITERIA: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION (I.E. PULMONARY OR CARDIAC FUNCTION).
Indications	All FDA-approved Indications.
Off Label Uses	

DELAFLOXACIN

Products Affected

- BAXDELA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE MONTH
Other Criteria	ACUTE BACTERIAL SKIN OR SKIN STRUCTURE INFECTION (ABSSSI): ONE OF THE FOLLOWING: 1) PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST, OR 2) ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO ONE STANDARD OF CARE AGENT FOR ABSSSI, OR 3) IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED FORMULARY AGENTS FOR ABSSSI: A PENICILLIN, A FLUOROQUINOLONE, A CEPHALOSPORIN, OR A GRAM POSITIVE TARGETING ANTIBIOTIC. COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA (CABP): ONE OF THE FOLLOWING: 1) PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST, OR 2) ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO AT LEAST TWO STANDARD OF CARE AGENTS FOR CABP, OR 3) IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO STANDARD OF CARE AGENTS FOR CABP.
Indications	All FDA-approved Indications.
Off Label Uses	

DENOSUMAB-XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DEUTETRABENAZINE

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	TARDIVE DYSKINESIA: PATIENT HAS A PRIOR HISTORY OF USING ANTIPSYCHOTIC MEDICATIONS OR METOCLOPRAMIDE PER PHYSICIAN ATTESTATION
Age Restrictions	
Prescriber Restrictions	HUNTINGTON DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DEXTROMETHORPHAN QUINIDINE

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	

DICHLORPHENAMIDE

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Exclusion Criteria	HEPATIC INSUFFICIENCY, PULMONARY OBSTRUCTION, OR A HEALTH CONDITION THAT WARRANTS CONCURRENT USE OF HIGH-DOSE ASPIRIN
Required Medical Information	
Age Restrictions	18 YEARS AND OLDER
Prescriber Restrictions	
Coverage Duration	INITIAL: 2 MONTHS RENEWAL: 12 MONTHS
Other Criteria	RENEWAL REQUIRES PHYSICIAN ATTESTATION OF IMPROVEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

DICLOFENAC EPOLAMINE

Products Affected

- *diclofenac epolamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	

DICLOFENAC TOPICAL

Products Affected

- *diclofenac sodium topical gel 3 %*
- PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PENNSAID 2% TOPICAL SOLUTION: TRIAL OF OR CONTRAINDICATION TO FORMULARY DICLOFENAC SODIUM 1% TOPICAL GEL AND DICLOFENAC SODIUM 1.5% TOPICAL DROPS.
Indications	All FDA-approved Indications.
Off Label Uses	

DINUTUXIMAB

Products Affected

- UNITUXIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DIROXIMEL FUMARATE

Products Affected

- VUMERITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DRONABINOL

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	B VS D COVERAGE CONSIDERATION. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY REQUIRES A TRIAL OF OR CONTRAINDICATION TO CONVENTIONAL ANTIEMETIC THERAPIES. NO ADDITIONAL REQUIREMENTS FOR A DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS.
Indications	All FDA-approved Indications.
Off Label Uses	

DRONABINOL ORAL SOLUTION

Products Affected

- SYNDROS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	B VS D COVERAGE CONSIDERATION. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY REQUIRES A TRIAL OF OR CONTRAINDICATION TO FORMULARY DRONABINOL CAPSULES AND ONE CONVENTIONAL ANTIEMETIC THERAPY. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS REQUIRES A TRIAL OF OR CONTRAINDICATION TO FORMULARY DRONABINOL CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	

DROXIDOPA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE (LYING FACE UP) POSITION AT BASELINE AND RENEWAL.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF ORTHOSTATIC HYPOTENSION AS DOCUMENTED BY A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION. RENEWAL: PATIENT HAD AN INCREASE IN SYSTOLIC BLOOD PRESSURE FROM BASELINE OF AT LEAST 10 MMHG UPON STANDING FROM A SUPINE (LYING FACE UP) POSITION.
Indications	All FDA-approved Indications.
Off Label Uses	

DUPILUMAB

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: ASTHMA: CONCURRENT USE OF XOLAIR OR ANTI-IL5 BIOLOGICS.
Required Medical Information	INITIAL APPROVAL FOR EOSINOPHILIC ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ATOPIC DERMATITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. CHRONIC RHINOSINUSITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL: ATOPIC DERMATITIS, CRSWNP: 6 MOS, ASTHMA: 12 MOS. RENEWAL: 12 MOS (ALL INDICATIONS).
Other Criteria	INITIAL APPROVAL FOR ATOPIC DERMATITIS REQUIRES: 1) PREVIOUS TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: TOPICAL CORTICOSTEROIDS, TOPICAL CALCINEURIN INHIBITORS OR TOPICAL PDE4 INHIBITOR. 2) ATOPIC DERMATITIS INVOLVING AT LEAST 10% OF BODY SURFACE AREA (BSA) OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS. 3) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN. INITIAL APPROVAL FOR ASTHMA: 1) PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION. 2) PATIENT HAS EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3

PA Criteria	Criteria Details
	<p>DAYS). INITIAL APPROVAL FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP) REQUIRES: 1) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY OR SINUS CT SCAN, 2) PATIENT HAS INADEQUATELY CONTROLLED DISEASE AS DETERMINED BY THE USE OF SYSTEMIC STEROIDS IN THE PAST 2 YEARS OR ENDOSCOPIC SINUS SURGERY. RENEWAL FOR ATOPIC DERMATITIS AND CHRONIC RHINOSINUSITIS: PATIENT IMPROVEMENT ON THERAPY. RENEWAL FOR ASTHMA: PATIENT HAS SHOWN A CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR 4) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS.</p>
Indications	All FDA-approved Indications.
Off Label Uses	

DURVALUMAB

Products Affected

- IMFINZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DUVELISIB

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

EDARAVONE

Products Affected

- RADICAVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELAGOLIX SODIUM

Products Affected

- ORLISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 YEARS OF AGE AND OLDER
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS; PREVIOUS TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING CONTRACEPTIVE PREPARATION. RENEWAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS; IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS.
Indications	All FDA-approved Indications.
Off Label Uses	

ELAPEGADEMASE-LVLR

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: ADENOSINE DEAMINASE SEVERE COMBINED IMMUNE DEFICIENCY (ADA-SCID): PRESCRIBED BY OR IN CONSULTATION WITH IMMUNOLOGIST, HEMATOLOGIST/ONCOLOGIST, OR PHYSICIAN SPECIALIZING IN INHERITED METABOLIC DISORDERS
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: ADA-SCID: ADA-SCID AS MANIFESTED BY ONE OF THE FOLLOWING: 1) CONFIRMATORY GENETIC TEST OR 2) SUGGESTIVE LABORATORY FINDINGS (E.G., ELEVATED DEOXYADENOSINE NUCLEOTIDE [DAXP] LEVELS, LYMPHOPENIA) AND HALLMARK SIGNS/SYMPTOMS (E.G., RECURRENT INFECTIONS, FAILURE TO THRIVE, PERSISTENT DIARRHEA). PATIENT ALSO MEETS ONE OF THE FOLLOWING: 1) HAS FAILED OR IS NOT A CANDIDATE FOR HEMATOPOIETIC CELL TRANSPLANTATION (HCT) OR 2) REVCOVI WILL BE USED AS BRIDGING THERAPY PRIOR TO PLANNED HCT OR GENE THERAPY. RENEWAL: ADA-SCID: IMPROVEMENT OR MAINTENANCE OF IMMUNE FUNCTION FROM BASELINE AND THE PATIENT HAS NOT RECEIVED SUCCESSFUL HCT OR GENE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

ELBASVIR/GRAZOPREVIR

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Exclusion Criteria	MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD PUGH B OR C)
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS. FOR GENOTYPE 1A - TESTING FOR NS5A RESISTANCE-ASSOCIATED POLYMORPHISMS.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. NO CONCURRENT USE WITH THE FOLLOWING AGENTS: PHENYTOIN, CARBAMAZEPINE, RIFAMPIN, EFAVIRENZ, ATAZANAVIR, DARUNAVIR, LOPINAVIR, SAQUINAVIR, TIPRANAVIR, CYCLOSPORINE, NAFCILLIN, KETOCONAZOLE, MODAFINIL, BOSENTAN, ETRAVIRINE, ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR, ATORVASTATIN AT DOSES GREATER THAN 20MG PER DAY OR ROSUVASTATIN AT DOSES GREATER THAN 10MG PER DAY.
Indications	All FDA-approved Indications.
Off Label Uses	

ELEXACFTOR-TEZACFTOR-IVACFTOR

Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: LIFETIME.
Other Criteria	RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	

ELIGLUSTAT TARTRATE

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELOSULFASE ALFA

Products Affected

- VIMIZIM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELOTUZUMAB

Products Affected

- EMLICITI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELTROMBOPAG

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST
Coverage Duration	ITP: INITIAL: 2 MO. RENEW: 12 MO. HCV: 12 MO. SEVERE APLASTIC ANEMIA: 12 MO.
Other Criteria	CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA PURPURA (ITP): INITIAL: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ALL INDICATIONS: APPROVAL FOR PROMACTA ORAL SUSPENSION PACKETS REQUIRES A TRIAL OF PROMACTA TABLETS OR PHYSICIAN ATTESTATION THAT THE PATIENT IS UNABLE TO TAKE TABLET FORMULATION. ITP: RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.
Indications	All FDA-approved Indications.
Off Label Uses	

ENASIDENIB

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENCORAFENIB

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENDOTHELIN RECEPTOR ANTAGONISTS

Products Affected

- *ambrisentan*
- OPSUMIT
- TRACLEER ORAL TABLET
- TRACLEER ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. AMBRISENTAN: PATIENT DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS (IPF). FORMULARY VERSION OF BOSENTAN: PATIENT DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASES IN BILIRUBIN BY 2 OR MORE TIMES ULN. PATIENT IS NOT CONCURRENTLY TAKING CYCLOSPORINE A OR GLYBURIDE. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.
Indications	All FDA-approved Indications.
Off Label Uses	

ENFORTUMAB

Products Affected

- PADCEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENTRECTINIB

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENZALUTAMIDE

Products Affected

- XTANDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: CASTRATION RESISTANT PROSTATE CANCER (CRPC) THAT IS NOT METASTATIC: THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). CRPC (INCLUDES NON-METASTATIC AND METASTATIC) OR METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): PATIENT MEETS ONE OF THE FOLLOWING: (1) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST OR ANTAGONIST OR (2) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY. RENEWAL: A DIAGNOSIS OF CRPC (INCLUDES NON-METASTATIC AND METASTATIC) OR MCSPC.
Indications	All FDA-approved Indications.
Off Label Uses	

EPOPROSTENOL IV

Products Affected

- *epoprostenol (glycine)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT HAS SHOWN IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

EPTINEZUMAB-JJMR

Products Affected

- VYEPTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT. RENEWAL: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH, OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH VYEPTI THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

ERDAFITINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ERENUMAB-AOOE

Products Affected

- AIMOVIG AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL FOR MIGRAINE: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT. RENEWAL FOR MIGRAINE: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH AIMOVIG THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

ERLOTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ERYTHROPOIESIS STIMULATING AGENTS - RETACRIT

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>INITIAL: CHRONIC KIDNEY DISEASE (CKD), ANEMIA RELATED TO ZIDOVUDINE THERAPY, OR CANCER CHEMOTHERAPY: A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. ELECTIVE NON-CARDIAC OR NON-VASCULAR SURGERY: A HEMOGLOBIN LEVEL LESS THAN 13G/DL. RENEWAL: CKD DIAGNOSIS REQUIRES ONE OF THE FOLLOWING: 1) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO ZIDOVUDINE THERAPY: A HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY: A HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL OR THAT THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE:12 MONTHS. SURGERY:1 MONTH.
Other Criteria	<p>RENEWAL: CKD: PATIENT IS NOT RECEIVING DIALYSIS TREATMENT. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</p>

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

ESKETAMINE

Products Affected

- SPRAVATO NASAL SPRAY, NON-AEROSOL 56 MG (28 MG X 2), 84 MG (28 MG X 3)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT (IMPROVEMENT IN DEPRESSION) COMPARED TO BASELINE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	MEETS ALL OF THE FOLLOWING: 1) PATIENT HAS NON-PSYCHOTIC, UNIPOLAR DEPRESSION, 2) PATIENT DOES NOT HAVE ACTIVE SUBSTANCE ABUSE, AND 3) PHYSICIAN ATTESTATION OF ADEQUATE TRIAL (AT LEAST 4 WEEKS) OF AT LEAST TWO ANTIDEPRESSANT AGENTS FROM DIFFERENT CLASSES THAT ARE INDICATED FOR DEPRESSION.
Indications	All FDA-approved Indications.
Off Label Uses	

ETANERCEPT

Products Affected

- ENBREL
- ENBREL SURECLICK
- ENBREL MINI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA.
Age Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, PSORIATIC ARTHRITIS: 18 YEARS OR OLDER
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AN NSAID. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY. RENEWAL: RA, PJIA, PSA, AS, PSO: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

ETEPLIRSEN

Products Affected

- EXONDYS-51

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PHYSICIAN ATTESTATION OF GENETIC TESTING CONFIRMING THAT MUTATION IN DUCHENNE MUSCULAR DYSTROPHY (DMD) GENE IS AMENABLE TO EXON 51 SKIPPING.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 24 WEEKS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL CRITERIA: PATIENT IS AMBULATORY AND IS CURRENTLY RECEIVING TREATMENT WITH OR HAS A CONTRAINDICATION TO CORTICOSTEROIDS. RENEWAL CRITERIA: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION (I.E. PULMONARY OR CARDIAC FUNCTION) DURING THE PAST 24 WEEKS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

EVEROLIMUS

Products Affected

- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED RENAL CELL CARCINOMA (RCC): TRIAL OF OR CONTRAINDICATION TO SUTENT OR NEXAVAR.
Indications	All FDA-approved Indications.
Off Label Uses	

EVOLOCUMAB

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	<p>INITIAL: HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH): DIAGNOSIS DETERMINED BY (1) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA, (2) DUTCH LIPID NETWORK CRITERIA SCORE OF 8 OR GREATER, OR (3) A CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. INITIAL: ALL INDICATIONS: LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. MEETS ONE OF THE FOLLOWING: (1) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), (4) STATIN INTOLERANCE, OR (5) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).</p>

PA Criteria	Criteria Details
	RENEWAL: ALL INDICATIONS: PATIENT MEETS ONE OF THE FOLLOWING: 1) CONTINUED CONCURRENT THERAPY WITH A MAXIMALLY TOLERATED DOSE OF A STATIN, 2) STATIN INTOLERANCE, OR 3) A CONTRAINDICATION TO STATIN THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

FAM-TRASTUZUMAB

Products Affected

- ENHERTU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FEDRATINIB

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MYELOFIBROSIS: TRIAL OF OR CONTRAINDICATION TO FORMULARY VERSION OF JAKAFI (RUXOLITINIB). RENEWAL: MYELOFIBROSIS: SYMPTOM IMPROVEMENT BY ONE OF THE FOLLOWING: 1) SPLEEN VOLUME REDUCTION OF 35% OR GREATER FROM BASELINE SPLEEN VOLUME AFTER 6 MONTHS OF THERAPY, 2) 50% OR GREATER REDUCTION IN TOTAL SYMPTOM SCORE ON THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF) V2.0, OR 3) 50% OR GREATER REDUCTION IN PALPABLE SPLEEN LENGTH.
Indications	All FDA-approved Indications.
Off Label Uses	

FENFLURAMINE

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL: PATIENT HAS SHOWN CONTINUED CLINICAL BENEFIT (E.G. REDUCTION OF SEIZURES, REDUCED LENGTH OF SEIZURES, SEIZURE CONTROL MAINTAINED)
Indications	All FDA-approved Indications.
Off Label Uses	

FENTANYL NASAL SPRAY

Products Affected

- LAZANDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER RELATED PAIN: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION. EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. TRIAL OR CONTRAINDICATION TO GENERIC FENTANYL CITRATE LOZENGE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

FENTANYL TRANSMUCOSAL AGENTS - FENTANYL CITRATE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER RELATED PAIN: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION. EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

FILGRASTIM

Products Affected

- GRANIX
- NEUPOGEN
- NIVESTYM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	A TRIAL OF OR CONTRAINDICATION TO ZARXIO IS REQUIRED EXCEPT WHEN USED TO INCREASE SURVIVAL IN A PATIENT ACUTELY EXPOSED TO MYELOSUPPRESSIVE DOSES OF RADIATION (HEMATOPOIETIC SYNDROME OF ACUTE RADIATION SYNDROME).
Indications	All FDA-approved Indications.
Off Label Uses	

FINGOLIMOD

Products Affected

- GILENYA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FOSTAMATINIB

Products Affected

- TAVALISSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FREMANEZUMAB-VFRM

Products Affected

- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL FOR MIGRAINE: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT. RENEWAL FOR MIGRAINE: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH AJOVY THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

GALCANEZUMAB-GNLM

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: MIGRAINES: 6 MOS. CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL INDICATIONS): 12 MONTHS.
Other Criteria	INITIAL FOR MIGRAINES: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT. CLUSTER HEADACHE: NO STEP. RENEWAL FOR MIGRAINES: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH EMGALITY THERAPY. RENEWAL FOR EPISODIC CLUSTER HEADACHE: IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

GEFITINIB

Products Affected

- IRESSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GEMTUZUMAB OZOGAMICIN

Products Affected

- MYLOTARG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GILTERITINIB

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GIVOSIRAN

Products Affected

- GIVLAARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ACUTE HEPATIC PORPHYRIA (AHP): INITIAL: GENETIC CONFIRMATION OF MUTATION OR ELEVATED URINARY OR PLASMA PBG (PORPHOBILINOGEN) OR ALA (AMINOLEVULINIC ACID).
Age Restrictions	
Prescriber Restrictions	ACUTE HEPATIC PORPHYRIA (AHP): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GENETICIST, HEPATOLOGIST, HEMATOLOGIST, GASTROENTEROLOGIST, NEUROLOGIST, DERMATOLOGIST, OR A HEALTHCARE PROVIDER EXPERIENCED IN MANAGING AHP.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	AHP: INITIAL: HAS EXPERIENCED TWO OR MORE ACUTE HEPATIC PORPHYRIA (AHP) ATTACKS IN THE PAST 12 MONTHS. RENEWAL: 1) HAS ACHIEVED OR MAINTAINED CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) HAS NOT RECEIVED A LIVER TRANSPLANT.
Indications	All FDA-approved Indications.
Off Label Uses	

GLASDEGIB

Products Affected

- DAURISMO ORAL TABLET 100 MG,
25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GLATIRAMER ACETATE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GLECAPREVIR/PIBRENTASVIR

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Exclusion Criteria	MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD PUGH B OR C)
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED OR CONTRAINDICATED BY THE MANUFACTURER: CARBAMAZEPINE, RIFAMPIN, ETHINYL ESTRADIOL-CONTAINING MEDICATION, ATAZANAVIR, DARUNAVIR, LOPINAVIR, RITONAVIR, EFAVIRENZ, ATORVASTATIN, LOVASTATIN, SIMVASTATIN, ROSUVASTATIN AT DOSES GREATER THAN 10MG, OR CYCLOSPORINE AT DOSES GREATER THAN 100MG PER DAY. PATIENT MUST NOT HAVE PRIOR FAILURE OF A DAA REGIMEN WITH NS5A INHIBITOR AND HCV PROTEASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	

GLYCEROL PHENYLBUTYRATE

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: UREA CYCLE DISORDER (UCD): DIAGNOSIS IS CONFIRMED BY ENZYMATIC, BIOCHEMICAL OR GENETIC TESTING
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: UREA CYCLE DISORDER (UCD): TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYLBUTYRATE (BUPHENYL). RENEWAL: UCD: PATIENT HAS CLINICAL BENEFIT FROM BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

GOLIMUMAB IV

Products Affected

- SIMPONI ARIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. RENEWAL: RA, PSA, AS: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

GOLIMUMAB SQ

Products Affected

- SIMPONI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA. RENEWAL FOR RA, PSA, OR AS: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

GUSELKUMAB

Products Affected

- TREMFYA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. RENEWAL: PSO: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

HYDROXYUREA

Products Affected

- SIKLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IBRUTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IBUPROFEN-FAMOTIDINE

Products Affected

- DUEXIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF ONE OF THE FOLLOWING GENERIC, FEDERAL LEGEND HISTAMINE H2-RECEPTOR ANTAGONISTS: FAMOTIDINE, CIMETIDINE, NIZATIDINE, OR RANITIDINE, AND TRIAL OF GENERIC, FEDERAL LEGEND IBUPROFEN.
Indications	All FDA-approved Indications.
Off Label Uses	

ICATIBANT

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ALLERGIST/IMMUNOLOGIST OR HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING.
Indications	All FDA-approved Indications.
Off Label Uses	

IDELALISIB

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IMATINIB MESYLATE

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ADJUVANT GASTROINTESTINAL STROMAL TUMOR TREATMENT: 36 MONTHS. ALL OTHER DIAGNOSES: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INFLIXIMAB

Products Affected

- REMICADE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX,

PA Criteria	Criteria Details
	ENBREL. CROHN'S DISEASE (CD): 1) PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA FOR PATIENTS 18 YEARS OF AGE AND OLDER OR 2) PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA FOR PATIENTS 6 TO 17 YEARS OLD. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA FOR PATIENTS 18 YEARS OF AGE AND OLDER. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

INFLIXIMAB-ABDA

Products Affected

- RENFLEXIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. PLAQUE PSORIASIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX,

PA Criteria	Criteria Details
	ENBREL. CROHN'S DISEASE (CD): 1) PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA FOR PATIENTS 18 YEARS OF AGE AND OLDER OR 2) PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA FOR PATIENTS 6 TO 17 YEARS OLD. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA FOR PATIENTS 18 YEARS OF AGE AND OLDER. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

INFLIXIMAB-AXXQ

Products Affected

- AVSOLA

PA Criteria	Criteria Details
Exclusion Criteria	