MASS ADVANTAGE

2026

Prior Authorization Requirements

For members in the following plans:

Mass Advantage Basic (HMO)

Mass Advantage Plus (HMO)

Mass Advantage Premiere (PPO)

Mass Advantage Extra (PPO)

ACTIMMUNE PA

MEDICATION(S)
ACTIMMUNE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ACYCLOVIR TOPICAL PA

MEDICATION(S)
ACYCLOVIR 5% OINTMENT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AIMOVIG PA

MEDICATION(S)
AIMOVIG AUTOINJECTOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of migraine AND 2. The requested agent is being used for migraine prophylaxis AND 3. Patient has 4 or more migraine headache days per month AND 4. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of migraine AND 3. The requested agent is being used for migraine prophylaxis AND 4. Patient has had clinical benefit with the requested agent AND 5. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

ALCOHOL SWABS PA

MEDICATION(S)
ISOPROPYL ALCOHOL 0.7 ML/ML MEDICATED PAD

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
This program will be implemented as a dynamic PA. Criteria for approval require BOTH of the following: 1. The requested medical supply product will be used in the delivery of insulin to the body AND 2. Patient's medication history includes use of insulin within the past 180 days

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ALOSETRON PA

MEDICATION(S)
ALOSETRON HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. Patient has a diagnosis of irritable bowel syndrome with severe diarrhea (IBS-D) AND 2. Patient's sex is female AND 3. Patient exhibits at least ONE of the following: a. Frequent and severe abdominal pain/discomfort OR b. Frequent bowel urgency or fecal incontinence OR c. Disability or restriction of daily activities due to IBS AND 4. Prescriber has ruled out anatomic or biochemical abnormalities of the gastrointestinal tract

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ALPHA-1-PROTEINASE INHIBITOR PA - PROLASTIN-C

MEDICATION(S)
PROLASTIN C

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of alpha-1 antitrypsin deficiency (AATD) with clinically evident emphysema AND 2. Patient has a pre-treatment serum alpha-1 antitrypsin (AAT) level less than 11 micromol/L (80 mg/dL by immunodiffusion or 57 mg/dL using nephelometry) AND 3. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of alpha-1 antitrypsin deficiency (AATD) with clinically evident emphysema AND 3. Patient has had clinical benefit with the requested agent AND 4. The requested dose is within FDA labeled dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

ANABOLIC STEROID PA - DANAZOL

MEDICATION(S)
DANAZOL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has ONE of the following diagnoses: A. Patient has an FDA labeled indication for the requested agent OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR B. Prescriber has provided information in support of therapy with more than one agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ANDROGEN INJECTABLE PA - TESTOSTERONE CYPIONATE

MEDICATION(S)

DEPO-TESTOSTERONE, TESTOSTERONE CYP 1,000 MG/10ML, TESTOSTERONE CYP 1,000 MG/5 ML, TESTOSTERONE CYP 100 MG/ML, TESTOSTERONE CYP 2,000 MG/10ML, TESTOSTERONE CYP 200 MG/ML, TESTOSTERONE CYP 500 MG/2.5 ML, TESTOSTERONE CYP 500 MG/5 ML, TESTOSTERONE CYP 6,000 MG/30ML

PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION

Criteria for approval require ALL of the following: 1. Patient has ONE of the following diagnoses: A. Patient's sex is male with AIDS/HIV-associated wasting syndrome AND BOTH of the following: i. ONE of the following: a. Unexplained involuntary weight loss (greater than 10% baseline body weight within 12 months, or 7.5% within 6 months) OR b. Body mass index less than 20 kg/m2 OR c. At least 5% total body cell mass (BCM) loss within 6 months OR d. BCM less than 35% of total body weight and BMI less than 27 kg/m2 AND ii. All other causes of weight loss have been ruled out OR B. Patient's sex is female with metastatic/inoperable breast cancer OR C. Patient's sex is male with primary or secondary (hypogonadotropic) hypogonadism OR D. Patient's sex is male and is an adolescent with delayed puberty AND 2. If the patient's sex is a male, ONE of the following: A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels: i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels: i. Total serum testosterone level that is within the testing laboratory's normal range OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR ii. Free serum testosterone level is within the testing laboratory's normal range OR below the testing laboratory's normal range AND 3. ONE of the following: A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR B. Prescriber has provided information in support of therapy with more than one agent

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approval will be 6 months for delayed puberty, 12 months for all other indications

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

ANDROGEN INJECTABLE PA - TESTOSTERONE ENANTHATE

MEDICATION(S)
TESTOSTERONE ENANTHATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. Patient has ONE of the following diagnoses: A. Patient's sex is male with AIDS/HIV-associated wasting syndrome AND BOTH of the following: i. ONE of the following: a. Unexplained involuntary weight loss (greater than 10% baseline body weight within 12 months, or 7.5% within 6 months) OR b. Body mass index less than 20 kg/m2 OR c. At least 5% total body cell mass (BCM) loss within 6 months OR d. BCM less than 35% of total body weight and BMI less than 27 kg/m2 AND ii. All other causes of weight loss have been ruled out OR B. Patient's sex is female with metastatic/inoperable breast cancer OR C. Patient's sex is male with primary or secondary (hypogonadotropic) hypogonadism OR D. Patient's sex is male and is an adolescent with delayed puberty AND 2. If the patient's sex is a male, ONE of the following: A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels: i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels: i. Total serum testosterone level that is within the testing laboratory's normal range OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR ii. Free serum testosterone level is within the testing laboratory's normal range OR below the testing laboratory's normal range AND 3. ONE of the following: A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR B. Prescriber has provided information in support of therapy with more than one agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approval will be 6 months for delayed puberty, 12 months for all other indications

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

ANDROGEN TOPICAL PA

MEDICATION(S)

TESTOSTERONE 1% (25MG/2.5G) PK, TESTOSTERONE 1% (50 MG/5 G) PK, TESTOSTERONE 1.62% (2.5 G) PKT, TESTOSTERONE 1.62% GEL PUMP, TESTOSTERONE 1.62%(1.25 G) PKT, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT

PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION

Criteria for approval require ALL of the following: 1. Patient has ONE of the following diagnoses: A. Patient has AIDS/HIV-associated wasting syndrome AND BOTH of the following: i. ONE of the following: a. Unexplained involuntary weight loss (greater than 10% baseline body weight within 12 months, or 7.5% within 6 months) OR b. Body mass index less than 20 kg/m2 OR c. At least 5% total body cell mass (BCM) loss within 6 months OR d. In men: BCM less than 35% of total body weight and BMI less than 27 kg/m2 OR e. In women: BCM less than 23% of total body weight and BMI less than 27 kg/m2 AND ii. All other causes of weight loss have been ruled out OR B. Patient's sex is male with primary or secondary (hypogonadotropic) hypogonadism AND 2. If the patient's sex is male, ONE of the following: A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels: i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels: i. Total serum testosterone level that is within the testing laboratory's normal range OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR ii. Free serum testosterone level is within the testing laboratory's normal range OR below the testing laboratory's normal range AND 3. ONE of the following: A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR B. Prescriber has submitted information in support of therapy with more than one agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ANTIPSYCHOTICS PA

MEDICATION(S)

ARIPIPRAZOLE, ARIPIPRAZOLE ODT, ASENAPINE MALEATE, CHLORPROMAZINE 10 MG TABLET, CHLORPROMAZINE 100 MG TABLET, CHLORPROMAZINE 100 MG/ML CONC, CHLORPROMAZINE 200 MG TABLET, CHLORPROMAZINE 25 MG TABLET, CHLORPROMAZINE 30 MG/ML CONC, CHLORPROMAZINE 50 MG TABLET, CLOZAPINE, CLOZAPINE ODT, FANAPT 1 MG TABLET, FANAPT 10 MG TABLET, FANAPT 12 MG TABLET, FANAPT 2 MG TABLET, FANAPT 4 MG TABLET, FANAPT 6 MG TABLET, FANAPT 8 MG TABLET, FANAPT TITRATION PACK A, FANAPT TITRATION PACK C, FLUPHENAZINE DECANOATE, FLUPHENAZINE HCL, HALOPERIDOL, HALOPERIDOL DECANOATE, HALOPERIDOL DECANOATE 100, HALOPERIDOL LACTATE, LOXAPINE, LURASIDONE HCL, LYBALVI, MOLINDONE HCL, OLANZAPINE, OLANZAPINE ODT, OPIPZA, PALIPERIDONE ER, PERPHENAZINE, PIMOZIDE, QUETIAPINE FUMARATE, QUETIAPINE FUMARATE ER, REXULTI 0.25 MG TABLET, REXULTI 0.5 MG TABLET, REXULTI 1 MG TABLET, REXULTI 2 MG TABLET, REXULTI 3 MG TABLET, REXULTI 4 MG TABLET, RISPERIDONE 1 MG/ML SOLUTION, RISPERIDONE ODT, SECUADO, THIORIDAZINE HCL, THIOTHIXENE, TRIFLUOPERAZINE HCL, VERSACLOZ, ZIPRASIDONE MESYLATE

PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has discussed the risk

of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

APOMORPHINE INJ PA

MEDICATION(S)
APOMORPHINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. The requested agent will be used to treat acute, intermittent hypomobility, off episodes (end of dose wearing off and unpredictable on/off episodes) associated with advanced Parkinson's disease AND 2. The requested agent will be used in combination with agents used for therapy in Parkinson's disease (e.g., levodopa, dopamine agonist, monoamine oxidase B inhibitor)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

ARCALYST PA

MEDICATION(S)
ARCALYST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. ONE of the following: A. Patient has been diagnosed with Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Auto-inflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS) OR B. BOTH of the following: i. Patient has a diagnosis of deficiency of interleukin-1 receptor antagonist AND ii. The requested agent is being used for maintenance of remission OR C. BOTH of the following: i. Patient has a diagnosis of recurrent pericarditis AND ii. The requested agent is being used to reduce the risk of recurrence AND 2. Patient will NOT be using the requested agent in combination with another biologic agent

AGE RESTRICTION
For diagnosis of CAPS including FCAS or MWS, patient is 12 years of age or over. For diagnosis of recurrent pericarditis and reduction in risk of recurrence, patient is 12 years of age or over.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

ARIKAYCE PA

MEDICATION(S)
ARIKAYCE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of Mycobacterium avium complex (MAC) lung disease AND 2. Patient has not achieved negative sputum cultures despite at least 6 consecutive months of treatment with standard combination antibiotic therapy for MAC lung disease [e.g., standard combination may include a macrolide (clarithromycin, azithromycin), a rifamycin (rifampin, rifabutin), and ethambutol] AND 3. Patient will continue treatment with a combination antibiotic therapy for MAC lung disease with the requested agent [e.g., combination may include a macrolide (clarithromycin, azithromycin), a rifamycin (rifampin, rifabutin), and ethambutol] Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of Mycobacterium avium complex (MAC) lung disease AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will continue treatment with a combination antibiotic therapy for MAC lung disease with the requested agent [e.g., combination may include a macrolide (clarithromycin, azithromycin), a rifamycin (rifampin, rifabutin), and ethambutol]

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., infectious disease, immunologist, pulmonologist, thoracic specialist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

ARMODAFINIL PA

MEDICATION(S)
ARMODAFINIL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another target agent (i.e., modafinil)

AGE RESTRICTION
Patient is 17 years of age or over

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ATOPIC DERMATITIS PA - EUCRISA

MEDICATION(S)
EUCRISA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has a diagnosis of atopic dermatitis AND 2. ONE of the following: A. Patient has tried and had an inadequate response to a topical corticosteroid or topical corticosteroid combination preparation (e.g., hydrocortisone, triamcinolone) OR B. Patient has an intolerance or hypersensitivity to a topical corticosteroid or topical corticosteroid combination preparation OR C. Patient has an FDA labeled contraindication to a topical corticosteroid or topical corticosteroid combination preparation

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

ATOPIC DERMATITIS PA - TACROLIMUS

MEDICATION(S)
TACROLIMUS 0.03% OINTMENT, TACROLIMUS 0.1% OINTMENT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require ONE of the following: 1. Patient has a diagnosis of atopic dermatitis AND ONE of the following: A. Patient has tried and had an inadequate response to a topical corticosteroid or topical corticosteroid combination preparation (e.g., hydrocortisone, triamcinolone) OR B. Patient has an intolerance or hypersensitivity to a topical corticosteroid or topical corticosteroid combination preparation OR C. Patient has an FDA labeled contraindication to a topical corticosteroid or topical corticosteroid combination preparation OR 2. Patient has an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

ATOVAQUONE PA

MEDICATION(S)
ATOVAQUONE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: 1. Patient has a diagnosis of mild-to-moderate Pneumocystis jirovecii pneumonia OR 2. Patient is using the requested agent for prevention of Pneumocystis jirovecii pneumonia AND ii. ONE of the following: 1. Patient has an intolerance or hypersensitivity to trimethoprim/sulfamethoxazole (TMP/SMX) OR 2. Patient has an FDA labeled contraindication to trimethoprim/sulfamethoxazole (TMP/SMX) OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

ATTRUBY PA

MEDICATION(S)
ATTRUBY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of cardiomyopathy of wild type or variant transthyretin-mediated amyloidosis (ATTR-CM) AND 2. The diagnosis has been confirmed by testing [e.g., stannous pyrophosphate (PYP) scanning, monoclonal antibody studies, biopsy, scintigraphy, genetic testing (TTR genotyping)] AND 3. The requested agent will be used to reduce cardiovascular death and cardiovascular-related hospitalization AND 4. Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure AND 5. Patient has clinical manifestations of cardiomyopathy (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema) AND 6. Patient will NOT be using the requested agent in combination with Amvuttra or a tafamidis agent for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of cardiomyopathy of wild type or variant transthyretin-mediated amyloidosis (ATTR-CM) AND 3. The requested agent will be used to reduce cardiovascular death and cardiovascular-related hospitalization AND 4. Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure AND 5. Patient has had clinical benefit with the requested agent AND 6. Patient will NOT be using the requested agent in combination with Amvuttra or a tafamidis agent for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

AUSTEDO PA

MEDICATION(S)
AUSTEDO, AUSTEDO XR, AUSTEDO XR TITR(12-18-24-30MG)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. ONE of the following: A. Patient has a diagnosis of chorea associated with Huntington's disease AND BOTH of the following: i. ONE of the following: 1. Patient does NOT have a current diagnosis of depression OR 2. Patient has a current diagnosis of depression and is being treated for depression AND ii. ONE of the following: 1. Patient does NOT have a diagnosis of passive suicidal ideation and/or behavior OR 2. Patient has a diagnosis of passive suicidal ideation and/or behavior and must NOT be actively suicidal OR B. Patient has a diagnosis of tardive dyskinesia AND ONE of the following: i. Prescriber has reduced the dose of or discontinued any medications known to cause tardive dyskinesia (i.e., dopamine receptor blocking agents) OR ii. Prescriber has provided clinical rationale indicating that a reduced dose or discontinuation of any medications known to cause tardive dyskinesia is not appropriate AND 2. Patient will NOT be using the requested agent in combination with a monoamine oxidase inhibitor (MAOI) AND 3. Patient will NOT be using the requested agent in combination with reserpine

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

BELSOMRA PA

MEDICATION(S)
BELSOMRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BENIGN PROSTATIC HYPERPLASIA PA - TADALAFIL

MEDICATION(S)
TADALAFIL 2.5 MG TABLET, TADALAFIL 5 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Requested agent will be used to treat erectile dysfunction ONLY AND FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has a diagnosis of benign prostatic hyperplasia (BPH) AND 2. Patient has tried and had an insufficient response, intolerance or hypersensitivity, or FDA labeled contraindication to TWO alpha blocker agents (e.g., terazosin, doxazosin, tamsulosin)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BENLYSTA SC PA

MEDICATION(S)
BENLYSTA 200 MG/ML AUTOINJECT, BENLYSTA 200 MG/ML SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. ONE of the following: a. Patient has a diagnosis of active systemic lupus erythematosus (SLE) disease AND the following: i. Patient will continue standard SLE therapy [corticosteroids (e.g., methylprednisolone, prednisone), hydroxychloroquine, immunosuppressives (e.g., azathioprine, methotrexate, oral cyclophosphamide)] in combination with the requested agent OR b. Patient has a diagnosis of active lupus nephritis (LN) AND the following: i. Patient will continue standard LN therapy [corticosteroids (e.g., methylprednisolone, prednisone), immunosuppressives (e.g., azathioprine, mycophenolate)] in combination with the requested agent AND 2. Patient will NOT be using the requested agent in combination with another biologic agent Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: a. Patient has diagnosis of active systemic lupus erythematosus (SLE) disease AND the following: i. Patient will continue standard SLE therapy [corticosteroids (e.g., methylprednisolone, prednisone), hydroxychloroquine, immunosuppressives (e.g., azathioprine, methotrexate, oral cyclophosphamide)] in combination with the requested agent OR b. Patient has a diagnosis of active lupus nephritis (LN) AND the following: i. Patient will continue standard LN therapy [corticosteroids (e.g., methylprednisolone, prednisone), immunosuppressives (e.g., azathioprine, mycophenolate)] in combination with the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another biologic agent

AGE RESTRICTION
For diagnosis of active systemic lupus erythematosus (SLE) disease, patient is 5 years of age or over. For diagnosis of active lupus nephritis (LN), patient is 18 years of age or over.

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

BENZODIAZEPINES PA - CLOBAZAM

MEDICATION(S)
CLOBAZAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PA does NOT apply to patients less than 65 years of age. Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. BOTH of the following: i. Patient has ONE of the following diagnoses: a. Seizure disorder OR b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

BENZODIAZEPINES PA - CLORAZEPATE

MEDICATION(S)
CLORAZEPATE DIPOTASSIUM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PA does NOT apply to patients less than 65 years of age. Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. BOTH of the following: i. Patient has ONE of the following diagnoses: a. Seizure disorder OR b. Anxiety disorder AND ONE of the following: 1) Patient has tried and has an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR 2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR 3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR c. Alcohol withdrawal OR d. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

BENZODIAZEPINES PA - DIAZEPAM

MEDICATION(S)
DIAZEPAM 10 MG TABLET, DIAZEPAM 2 MG TABLET, DIAZEPAM 25 MG/5 ML ORAL CONC, DIAZEPAM 5 MG TABLET, DIAZEPAM 5 MG/5 ML ORAL CUP, DIAZEPAM 5 MG/5 ML SOLUTION, DIAZEPAM 5 MG/ML ORAL CONC

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PA does NOT apply to patients less than 65 years of age. Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. BOTH of the following: i. Patient has ONE of the following diagnoses: a. Seizure disorder OR b. Anxiety disorder AND ONE of the following: 1) Patient has tried and had an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR 2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR 3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR c. Skeletal muscle spasms OR d. Alcohol withdrawal OR e. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BENZODIAZEPINES PA - LORAZEPAM

MEDICATION(S)
LORAZEPAM 0.5 MG TABLET, LORAZEPAM 1 MG TABLET, LORAZEPAM 2 MG TABLET, LORAZEPAM 2 MG/ML ORAL CONCENT, LORAZEPAM INTENSOL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PA does NOT apply to patients less than 65 years of age. Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. BOTH of the following: i. Patient has ONE of the following diagnoses: a. Anxiety disorder AND ONE of the following: 1) Patient has tried and had an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR 2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR 3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

BENZODIAZEPINES PA - OXAZEPAM

MEDICATION(S)
OXAZEPAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PA does NOT apply to patients less than 65 years of age. Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. BOTH of the following: i. Patient has ONE of the following diagnoses: a. Anxiety disorder AND ONE of the following: 1) Patient has tried and had an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR 2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR 3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR b. Alcohol withdrawal OR c. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

BENZODIAZEPINES PA - SYMPAZAN

MEDICATION(S)
SYMPAZAN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PA does NOT apply to patients less than 65 years of age. Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. BOTH of the following: i. Patient has ONE of the following diagnoses: a. Seizure disorder OR b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

BEXAROTENE GEL PA

MEDICATION(S)
BEXAROTENE 1% GEL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. ALL of the following: i. ONE of the following: 1. BOTH of the following: a. Patient has a diagnosis of stage IA or IB cutaneous T-cell lymphoma (CTCL) with cutaneous lesions AND b. ONE of the following: i. Patient has refractory or persistent disease despite a previous treatment trial with a skin-directed therapy (e.g., topical corticosteroid, topical imiquimod) OR ii. Patient has an intolerance or hypersensitivity to a previous treatment trial with a skin-directed therapy (e.g., topical corticosteroid, topical imiquimod) OR iii. Patient has an FDA labeled contraindication to a previous treatment trial with a skin-directed therapy (e.g., topical corticosteroid, topical imiquimod) OR 2. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist, oncologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND iii. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 3. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. ALL of the following: i. Patient has had clinical benefit with the requested agent AND ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist, oncologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND iii. Patient does NOT have any FDA labeled contraindications to the requested agent

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

BIOLOGIC IMMUNOMODULATORS PA - ACTEMRA

MEDICATION(S)
ACTEMRA 162 MG/0.9 ML SYRINGE, ACTEMRA ACTPEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. ONE of the following: i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following: a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Use of TWO preferred agents (Hadlima, Rinvoq tablets, Rinvoq solution, or Simlandi) is required for diagnosis of polyarticular juvenile idiopathic arthritis Use of TWO preferred agents (Hadlima, Rinvoq tablets, or Simlandi) is required for diagnosis of rheumatoid arthritis Use of ONE preferred agent (Rinvoq tablets) is required for diagnosis of giant cell arteritis NO preferred agent is required for diagnoses of systemic sclerosis-associated interstitial lung disease (SSc-ILD), cytokine release syndrome, or systemic juvenile idiopathic arthritis

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BIOLOGIC IMMUNOMODULATORS PA - COSENTYX

MEDICATION(S)
COSENTYX (2 SYRINGES), COSENTYX SENSOREADY (2 PENS), COSENTYX SENSOREADY PEN, COSENTYX SYRINGE, COSENTYX UNOREADY PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Use of ONE conventional prerequisite agent is required for diagnosis of plaque psoriasis NO prerequisites are required for diagnoses of ankylosing spondylitis, enthesitis related arthritis, hidradenitis suppurativa, non-radiographic axial spondyloarthritis, or psoriatic arthritis Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BIOLOGIC IMMUNOMODULATORS PA - ENBREL

MEDICATION(S)
ENBREL 25 MG/0.5 ML SYRINGE, ENBREL 25 MG/0.5 ML VIAL, ENBREL 50 MG/ML SYRINGE, ENBREL MINI, ENBREL SURECLICK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. ONE of the following: i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following: a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Use of ONE preferred agent (Simlandi) is required for diagnoses of ankylosing spondylitis, psoriatic arthritis, adult plaque psoriasis, polyarticular juvenile idiopathic arthritis, or rheumatoid arthritis NO preferred agent is required for diagnoses of juvenile psoriatic arthritis or pediatric plaque psoriasis

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BIOLOGIC IMMUNOMODULATORS PA - ENTYVIO SC

MEDICATION(S)
ENTYVIO PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Use of ONE conventional prerequisite agent is required for diagnosis of Crohn's disease NO prerequisites are required for diagnoses of moderate ulcerative colitis or severe ulcerative colitis Formulary conventional agents for Crohn's disease include methotrexate, sulfasalazine, corticosteroids, azathioprine, or mercaptopurine

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BIOLOGIC IMMUNOMODULATORS PA - HADLIMA

MEDICATION(S)
HADLIMA, HADLIMA PUSHTOUCH, HADLIMA(CF), HADLIMA(CF) PUSHTOUCH

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Use of ONE conventional prerequisite agent is required for diagnoses of plaque psoriasis, rheumatoid arthritis, juvenile idiopathic arthritis, or Crohn's disease NO prerequisites are required for diagnoses of ankylosing spondylitis, hidradenitis suppurativa, psoriatic arthritis, moderate ulcerative colitis, severe ulcerative colitis, or uveitis Formulary conventional agents for rheumatoid arthritis or juvenile idiopathic arthritis include leflunomide, methotrexate, or sulfasalazine Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids Formulary conventional agents for Crohn's disease include methotrexate, sulfasalazine, corticosteroids, azathioprine, or mercaptopurine

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BIOLOGIC IMMUNOMODULATORS PA - ORENCIA

MEDICATION(S)
ORENCIA 125 MG/ML SYRINGE, ORENCIA 50 MG/0.4 ML SYRINGE, ORENCIA 87.5 MG/0.7 ML SYRINGE, ORENCIA CLICKJECT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. ONE of the following: i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following: a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Use of TWO preferred agents (Hadlima, Rinvoq tablets, Rinvoq solution, or Simlandi) is required for diagnosis of juvenile idiopathic arthritis Use of TWO preferred agents (Hadlima, Rinvoq tablets, or Simlandi) is required for diagnosis of rheumatoid arthritis For patients 18 years of age or over, use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Rinvoq tablets, Rinvoq solution, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of psoriatic arthritis For patients between 6 and less than 18 years of age, use of ONE preferred agent (Cosentyx) is required for diagnosis of psoriatic arthritis For patients between 2 and less than 6 years of age, NO preferred agent is required for diagnosis of psoriatic arthritis NO preferred agent is required for diagnosis of prophylaxis of acute graft vs host disease

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BIOLOGIC IMMUNOMODULATORS PA - RINVOQ SOLUTION

MEDICATION(S)
RINVOQ LQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. ONE of the following: i. Patient's medication history indicates use of preferred TNF agent(s) OR ii. Patient has an intolerance or hypersensitivity to preferred TNF agent(s) OR iii. Patient has an FDA labeled contraindication to preferred TNF agent(s) OR iv. The request is for an FDA labeled indication that is not covered by preferred TNF agent(s) AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

Use of ONE preferred TNF (Simlandi) is required for diagnoses of adult psoriatic arthritis or juvenile idiopathic arthritis NO preferred TNF agent is required for diagnosis of pediatric psoriatic arthritis

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

BIOLOGIC IMMUNOMODULATORS PA - RINVOQ TABLET

MEDICATION(S)
RINVOQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. ONE of the following: i. BOTH of the following: a. Patient has an FDA labeled indication other than moderate to severe atopic dermatitis for the requested agent AND b. ONE of the following: 1. Patient's medication history indicates use of preferred TNF agent(s) OR 2. Patient has an intolerance or hypersensitivity to preferred TNF agent(s) OR 3. Patient has an FDA labeled contraindication to preferred TNF agent(s) OR 4. The request is for an FDA labeled indication that is not covered by preferred TNF agent(s) OR ii. Patient has a diagnosis of moderate to severe atopic dermatitis AND ONE of the following: a. Patient's medication history indicates use of TWO conventional prerequisite agents (i.e., ONE formulary topical corticosteroid AND ONE formulary topical calcineurin inhibitor) for the requested indication OR b. Patient has an intolerance or hypersensitivity to TWO conventional prerequisite agents (i.e., ONE formulary topical corticosteroid AND ONE formulary topical calcineurin inhibitor) for the requested indication OR c. Patient has an FDA labeled contraindication to TWO conventional prerequisite agents (i.e., ONE formulary topical corticosteroid AND ONE formulary topical calcineurin inhibitor) for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Use of ONE preferred TNF (Simlandi) is required for diagnoses of ankylosing spondylitis, Crohn's disease, rheumatoid arthritis, adult psoriatic arthritis, juvenile idiopathic arthritis, or ulcerative colitis Use of TWO conventional prerequisite agents are required for diagnosis of moderate to severe atopic dermatitis NO preferred TNF agents are required for diagnoses of pediatric psoriatic arthritis, non-radiographic axial spondyloarthritis, or giant cell arteritis

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BIOLOGIC IMMUNOMODULATORS PA - SIMLANDI

MEDICATION(S)
SIMLANDI(CF), SIMLANDI(CF) AUTOINJECTOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Use of ONE conventional prerequisite agent is required for diagnoses of plaque psoriasis, rheumatoid arthritis, juvenile idiopathic arthritis, or Crohn's disease NO prerequisites are required for diagnoses of ankylosing spondylitis, hidradenitis suppurativa, psoriatic arthritis, moderate ulcerative colitis, severe ulcerative colitis, or uveitis Formulary conventional agents for rheumatoid arthritis or juvenile idiopathic arthritis include leflunomide, methotrexate, or sulfasalazine Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids Formulary conventional agents for Crohn's disease include methotrexate, sulfasalazine, corticosteroids, azathioprine, or mercaptopurine

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BIOLOGIC IMMUNOMODULATORS PA - SKYRIZI

MEDICATION(S)
SKYRIZI 150 MG/ML SYRINGE, SKYRIZI 600 MG/10 ML VIAL, SKYRIZI ON-BODY, SKYRIZI PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Use of ONE conventional prerequisite agent is required for diagnoses of Crohn's disease or plaque psoriasis NO prerequisites are required for diagnoses of psoriatic arthritis, moderate ulcerative colitis, or severe ulcerative colitis Formulary conventional agents for Crohn's disease include methotrexate, sulfasalazine, corticosteroids, azathioprine, or mercaptopurine Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BIOLOGIC IMMUNOMODULATORS PA - STELARA

MEDICATION(S)
STELARA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Use of ONE conventional prerequisite agent is required for diagnoses of plaque psoriasis or Crohn's disease NO prerequisites are required for diagnoses of psoriatic arthritis, moderate ulcerative colitis, or severe ulcerative colitis Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids Formulary conventional agents for Crohn's disease include methotrexate, sulfasalazine, corticosteroids, azathioprine, mercaptopurine

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BIOLOGIC IMMUNOMODULATORS PA - STEQEYMA

MEDICATION(S)
STEQEYMA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Use of ONE conventional prerequisite agent is required for diagnoses of plaque psoriasis or Crohn's disease NO prerequisites are required for diagnoses of psoriatic arthritis, moderate ulcerative colitis, or severe ulcerative colitis Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids Formulary conventional agents for Crohn's disease include methotrexate, sulfasalazine, corticosteroids, azathioprine, mercaptopurine

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BIOLOGIC IMMUNOMODULATORS PA - TREMFYA

MEDICATION(S)
TREMFYA 100 MG/ML SYRINGE, TREMFYA 200 MG/2 ML SYRINGE, TREMFYA ONE-PRESS, TREMFYA PEN, TREMFYA PEN INDUCTION PK-CROHN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Use of ONE conventional prerequisite agent is required for diagnoses of plaque psoriasis or Crohn's disease NO prerequisites are required for diagnoses of psoriatic arthritis, moderate ulcerative colitis, or severe ulcerative colitis Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids Formulary conventional agents for Crohn's disease include methotrexate, sulfasalazine, corticosteroids, azathioprine, or mercaptopurine

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BIOLOGIC IMMUNOMODULATORS PA - TYENNE

MEDICATION(S)
TYENNE 162 MG/0.9 ML SYRINGE, TYENNE AUTOINJECTOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. ONE of the following: i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following: a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Use of ONE preferred agent (Simlandi) is required for diagnoses of polyarticular juvenile idiopathic arthritis or rheumatoid arthritis NO preferred agent is required for diagnoses of cytokine release syndrome, giant cell arteritis, or systemic juvenile idiopathic arthritis

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BUDESONIDE ORAL ER PA - ENTOCORT

MEDICATION(S)
BUDESONIDE DR, BUDESONIDE EC

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BUDESONIDE ORAL ER PA - UCERIS

MEDICATION(S)
BUDESONIDE ER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CARGLUMIC PA

MEDICATION(S)
CARGLUMIC ACID

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA)

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has a diagnosis of ONE of the following: a. Acute hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) OR b. Chronic hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) OR c. Acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) AND 2. The requested dose is within FDA labeled dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist, nephrologist, metabolic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

CAYSTON PA

MEDICATION(S)
CAYSTON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. Patient has a diagnosis of cystic fibrosis AND 2. Documentation has been provided that indicates the patient has a Pseudomonas aeruginosa respiratory infection AND 3. ONE of the following: a. Patient is NOT currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled tobramycin) OR b. Patient is currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled tobramycin) AND ONE of the following: i. Prescriber has confirmed that the other inhaled antibiotic will be discontinued, and that therapy will be continued only with the requested agent OR ii. Prescriber has provided information in support of another inhaled antibiotic therapy used concurrently with or alternating with (i.e., continuous alternating therapy) the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

CHENODAL PA

MEDICATION(S)
CHENODAL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has a diagnosis of radiolucent stones in a well-opacifying gallbladder AND 2. The requested dose is within FDA labeled dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CHORIONIC GONADOTROPIN PA

MEDICATION(S)
CHORIONIC GONADOTROPIN, PREGNYL

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CINACALCET PA

MEDICATION(S)
CINACALCET HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has ONE of the following: A. A diagnosis of hypercalcemia due to parathyroid carcinoma OR B. A diagnosis of primary hyperparathyroidism (HPT) AND BOTH of the following: i. Patient has a pretreatment serum calcium level that is above the testing laboratory's upper limit of normal AND ii. Patient is unable to undergo parathyroidectomy OR C. Another indication that is FDA approved or supported in CMS approved compendia for the requested agent not otherwise excluded from Part D [i.e., secondary hyperparathyroidism due to end-stage renal disease (ESRD) on dialysis]

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

COBENFY PA

MEDICATION(S)
COBENFY, COBENFY STARTER PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. ALL of the following: i. Prescriber has assessed the patient's liver enzymes and bilirubin prior to starting therapy with the requested agent AND ii. Prescriber has assessed the patient's heart rate prior to starting therapy with the requested agent AND iii. ONE of the following: a. Patient has tried and had an inadequate response to TWO antipsychotic agents (e.g., aripiprazole, haloperidol, loxapine, olanzapine, quetiapine, risperidone) for the requested indication OR b. Patient has an intolerance or hypersensitivity to TWO antipsychotic agents (e.g., aripiprazole, haloperidol, loxapine, olanzapine, quetiapine, risperidone) OR c. Patient has an FDA labeled contraindication to TWO antipsychotic agents (e.g., aripiprazole, haloperidol, loxapine, olanzapine, quetiapine, risperidone) AND iv. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA

Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. ALL of the following: i. Prescriber has assessed the patient's liver enzymes and bilirubin as clinically indicated during treatment with the requested agent AND ii. Prescriber has assessed the patient's heart rate as clinically indicated during treatment with the requested agent AND iii. Patient does NOT have any FDA labeled contraindications to the requested agent AND iv. Patient has had clinical benefit with the requested agent

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

COLONY STIMULATING FACTORS PA - FULPHILA

MEDICATION(S)
FULPHILA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 6 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

COLONY STIMULATING FACTORS PA - GRANIX

MEDICATION(S)
GRANIX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 6 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

COLONY STIMULATING FACTORS PA - NIVESTYM

MEDICATION(S)
NIVESTYM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 6 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

COLONY STIMULATING FACTORS PA - UDENYCA

MEDICATION(S)
UDENYCA, UDENYCA AUTOINJECTOR, UDENYCA ONBODY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 6 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

COLONY STIMULATING FACTORS PA - ZIEXTENZO

MEDICATION(S)
ZIEXTENZO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 6 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CORLANOR PA

MEDICATION(S)
CORLANOR 5 MG/5 ML ORAL SOLN, IVABRADINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of following: A. ALL of the following: i. Patient has stable, symptomatic heart failure (e.g., NYHA Class II, III, IV: ACCF/AHA Class C, D) due to dilated cardiomyopathy (DCM) AND ii. The requested agent is for a pediatric patient, 6 months of age or over AND iii. Patient is in sinus rhythm with an elevated heart rate OR B. ALL of the following: i. Patient has stable, symptomatic chronic heart failure (e.g., NYHA Class II, III, IV: ACCF/AHA Class C, D) AND ii. The requested agent is for an adult patient AND iii. Patient has a baseline OR current left ventricular ejection fraction of 35% or less AND iv. Patient is in sinus rhythm with a resting heart rate of 70 beats or greater per minute prior to initiating therapy with the requested agent AND v. ONE of the following: a. Patient is on a maximally tolerated dose of beta blocker (e.g., bisoprolol, carvedilol, metoprolol) OR b. Patient has an intolerance, FDA labeled contraindications, or hypersensitivity to a beta blocker

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

CRESEMBA PA

MEDICATION(S)
CRESEMBA 186 MG CAPSULE, CRESEMBA 74.5 MG CAPSULE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of invasive aspergillosis OR B. Patient has a diagnosis of invasive mucormycosis OR C. Patient has another indication that is supported in CMS approved compendia for the requested agent Criteria for renewal approval require BOTH of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of invasive aspergillosis or invasive mucormycosis and patient has continued indicators of active disease (e.g., biomarkers in serum assay, microbiologic culture, radiographic evidence) OR B. BOTH of the following: i. Patient has another indication that is supported in CMS approved compendia for the requested agent AND ii. Patient has had clinical benefit with the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 6 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

CRYSVITA PA

MEDICATION(S)
CRYSVITA

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CYSTARAN PA

MEDICATION(S)
CYSTARAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., ophthalmologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CYSTINOSIS AGENTS PA - CYSTAGON

MEDICATION(S)
CYSTAGON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of nephropathic cystinosis AND 2. Prescriber has performed a baseline white blood cell (WBC) cystine level test AND 3. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of nephropathic cystinosis AND 3. Patient has had clinical benefit with the requested agent (e.g., decrease in WBC cystine levels from baseline) AND 4. The requested dose is within FDA labeled dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

DALFAMPRIDINE PA

MEDICATION(S)
DALFAMPRIDINE ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has a diagnosis of multiple sclerosis (MS) AND 2. ONE of the following: A. The requested agent will be used in combination with a disease modifying agent (e.g., dimethyl fumarate) OR B. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to a disease modifying agent OR C. Prescriber has provided information indicating that a disease modifying agent is not clinically appropriate for the patient Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of multiple sclerosis (MS) AND 3. ONE of the following: A. The requested agent will be used in combination with a disease modifying agent (e.g., dimethyl fumarate) OR B. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to a disease modifying agent OR C. Prescriber has provided information indicating that a disease modifying agent is not clinically appropriate for the patient AND 4. Patient has had improvements or stabilization from baseline in timed walking speed (timed 25-foot walk)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Initial approval will be for 3 months, renewal approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

DAYVIGO PA

MEDICATION(S)
DAYVIGO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DROXIDOPA PA

MEDICATION(S)
DROXIDOPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of neurogenic orthostatic hypotension (nOH) AND 2. Prescriber has performed baseline blood pressure readings while the patient is sitting or supine (lying face up), AND also within three minutes of standing from a supine position AND 3. Patient has a decrease of at least 20 mmHg in systolic blood pressure or 10 mmHg diastolic blood pressure within three minutes after standing AND 4. Patient has persistent and consistent symptoms of neurogenic orthostatic hypotension (nOH) caused by ONE of the following: A. Primary autonomic failure [Parkinson's disease (PD), multiple system atrophy, or pure autonomic failure] OR B. Dopamine beta-hydroxylase deficiency OR C. Non-diabetic autonomic neuropathy AND 5. Prescriber has assessed the severity of the patient's baseline symptoms of dizziness, lightheadedness, feeling faint, or feeling like the patient may black out AND 6. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of neurogenic orthostatic hypotension (nOH) AND 3. Patient has had improvements or stabilization with the requested agent as indicated by improvement in severity from baseline symptoms of ONE of the following: A. Dizziness B. Lightheadedness C. Feeling faint D. Feeling like the patient may black out AND 4. The requested dose is within FDA labeled dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist, neurologist) or the

prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION

Approval will be 1 month for initial, 3 months for renewal

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

DUPIXENT PA

MEDICATION(S)
DUPIXENT PEN, DUPIXENT 200 MG/1.14 ML SYRING, DUPIXENT 300 MG/2 ML SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of moderate-to-severe atopic dermatitis AND ALL of the following: i. ONE of the following: a. Patient has tried and failed a topical steroid (e.g., triamcinolone) OR b. Patient has an intolerance, hypersensitivity, or an FDA labeled contraindication to a topical steroid AND ii. For patients 2 years of age or over, ONE of the following: a. Patient has tried and failed a topical calcineurin inhibitor (e.g., tacrolimus) OR b. Patient has an intolerance, hypersensitivity, or an FDA labeled contraindication to a topical calcineurin inhibitor AND iii. Patient will NOT be using the requested agent in combination with another biologic agent or a JAK inhibitor for the requested indication OR B. Patient has a diagnosis of moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid dependent asthma AND BOTH of the following: i. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent AND ii. Patient will NOT be using the requested agent in combination with Xolair or with an injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Fasenra, Nucala) for the requested indication OR C. Patient has a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) AND the following: i. BOTH of the following: a. ONE of the following: 1. Patient has tried and had an inadequate response to an oral systemic corticosteroid AND an intranasal corticosteroid (e.g., fluticasone) OR 2. Patient has an intolerance, hypersensitivity, or an FDA labeled contraindication to an oral systemic corticosteroid AND an intranasal corticosteroid AND b. Patient will continue standard maintenance therapy (e.g., intranasal corticosteroid) in combination with the requested agent OR Initial criteria continues: see Other Criteria

AGE RESTRICTION
For diagnosis of moderate-to-severe atopic dermatitis, patient (pt) is 6 months of age or over. For diagnosis of moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid

dependent asthma, pt is 6 years of age or over. For diagnosis of CRSwNP OR CSU, pt is 12 years of age or over. For diagnosis of EoE, pt is 1 year of age or over. For diagnosis of PN, pt is 18 years of age or over. For diagnosis of COPD with an eosinophilic phenotype, pt is 18 years of age or over.

PRESCRIBER RESTRICTION

Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, dermatologist, immunologist, gastroenterologist, otolaryngologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

D. Patient has a diagnosis of eosinophilic esophagitis (EoE) confirmed by esophageal biopsy OR E. Patient has a diagnosis of prurigo nodularis (PN) OR F. Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) with an eosinophilic phenotype AND BOTH of the following: i. Patient is currently being treated with AND will continue COPD control therapy (e.g., ICS, LABA, LAMA) in combination with the requested agent AND ii. Patient will NOT be using the requested agent in combination with Xolair or with an injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Fasenra, Nucala) for the requested indication OR G. Patient has a diagnosis of chronic spontaneous urticaria (CSU) AND BOTH of the following: i. Patient has had over 6 weeks of hives and itching AND ii. ONE of the following: a. Patient has tried and had an inadequate response to a maximum tolerable H1 antihistamine therapy OR b. Patient has an intolerance, hypersensitivity, or an FDA labeled contraindication to a maximum tolerable H1 antihistamine therapy Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of moderate-to-severe atopic dermatitis AND the following: i. Patient will NOT be using the requested agent in combination with another biologic agent or a JAK inhibitor for the requested indication OR B. Patient has a diagnosis of moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid dependent asthma AND BOTH of the following: i. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent AND ii. Patient will NOT be using the requested agent in combination with Xolair or with an injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Fasenra, Nucala) for the requested indication OR C. Patient has a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) AND the following: i. Patient will continue standard maintenance therapy (e.g., intranasal corticosteroid) in combination with the requested agent OR D. Patient has a diagnosis of eosinophilic esophagitis (EoE) OR E. Patient has a diagnosis of prurigo nodularis (PN) OR F. Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) with an eosinophilic phenotype AND BOTH of the following: i.

Patient is currently being treated with AND will continue COPD control therapy (e.g., ICS, LABA, LAMA) in combination with the requested agent AND ii. Patient will NOT be using the requested agent in combination with Xolair or with an injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Fasenra, Nucala) for the requested indication OR G. Patient has a diagnosis of chronic spontaneous urticaria (CSU) AND 3. Patient has had clinical benefit with the requested agent

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

EMGALITY PA

MEDICATION(S)
EMGALITY PEN, EMGALITY SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of migraine AND ALL of the following: i. The requested agent is being used for migraine prophylaxis AND ii. Patient has 4 or more migraine headache days per month AND iii. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis OR B. Patient has a diagnosis of episodic cluster headache AND BOTH of the following: i. Patient has had at least 5 cluster headache attacks AND ii. Patient has had at least two cluster periods lasting 7 days to one year and separated by pain-free remission periods of 3 months or more Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. ALL of the following: i. Patient has a diagnosis of migraine AND ii. The requested agent is being used for migraine prophylaxis AND iii. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis OR B. Patient has a diagnosis of episodic cluster headache AND 3. Patient has had clinical benefit with the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

EMSAM PA

MEDICATION(S)
EMSAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. ONE of the following: A. Patient has a diagnosis of major depressive disorder (MDD) OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. BOTH of the following: i. ONE of the following: a. BOTH of the following: i. Patient has a diagnosis of major depressive disorder (MDD) AND ii. ONE of the following: 1. Patient has tried and had an inadequate response to at least two different oral antidepressants (e.g., selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), mirtazapine, bupropion) OR 2. Patient has an intolerance or hypersensitivity to at least two different oral antidepressants (e.g., selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), mirtazapine, bupropion) OR 3. Patient has an FDA labeled contraindication to at least two different oral antidepressants (e.g., selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), mirtazapine, bupropion) OR b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of major depressive disorder (MDD) OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND 3. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. BOTH of the following: i. Patient has had clinical benefit with the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

EPIDIOLEX PA

MEDICATION(S)
EPIDIOLEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has a diagnosis of seizures associated with ONE of the following: A. Lennox-Gastaut syndrome OR B. Dravet syndrome OR C. Tuberous sclerosis complex AND 2. The requested dose is within FDA labeled dosing for the requested indication

AGE RESTRICTION
Patient is within the FDA labeled age for the requested agent

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ERYTHROPOIETIN STIMULATING AGENTS PA - ARANESP

MEDICATION(S)

ARANESP 10 MCG/0.4 ML SYRINGE, ARANESP 100 MCG/0.5 ML SYRINGE, ARANESP 100 MCG/ML VIAL, ARANESP 150 MCG/0.3 ML SYRINGE, ARANESP 200 MCG/0.4 ML SYRINGE, ARANESP 200 MCG/ML VIAL, ARANESP 25 MCG/0.42 ML SYRING, ARANESP 25 MCG/ML VIAL, ARANESP 300 MCG/0.6 ML SYRINGE, ARANESP 40 MCG/0.4 ML SYRINGE, ARANESP 40 MCG/ML VIAL, ARANESP 500 MCG/1 ML SYRINGE, ARANESP 60 MCG/0.3 ML SYRINGE, ARANESP 60 MCG/ML VIAL

PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION

Criteria for approval require BOTH of the following: 1. The requested agent is being prescribed for ONE of the following: A. Anemia due to myelosuppressive chemotherapy for a non-myeloid malignancy AND ALL of the following: i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR less than 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND ii. Patient is being concurrently treated with chemotherapy with or without radiation (there must be a minimum of 2 additional months of planned chemotherapy) AND iii. The intent of chemotherapy is non-curative OR B. Anemia associated with chronic kidney disease in a patient NOT on dialysis AND ALL of the following: i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR 11 g/dL or less for patients stabilized on therapy (measured within the previous 4 weeks) AND ii. The rate of hemoglobin decline indicates the likelihood of requiring a RBC transfusion AND iii. The intent of therapy is to reduce the risk of alloimmunization and/or other RBC transfusion related risks OR C. Anemia due to myelodysplastic syndrome AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) OR D. Another indication that is supported in CMS approved compendia for the requested agent AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND 2. Patient's transferrin saturation and serum ferritin have been

evaluated Drug is also subject to Part B versus Part D review.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approval will be 6 months for chemotherapy, 12 months for other indications

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

ERYTHROPOIETIN STIMULATING AGENTS PA - EPOGEN/PROCRIT

MEDICATION(S)
PROCRIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. The requested agent is being prescribed for ONE of the following: A. To reduce the possibility of allogeneic blood transfusion in a surgery patient AND the patient's hemoglobin level is greater than 10 g/dL but less than or equal to 13 g/dL OR B. Anemia due to myelosuppressive chemotherapy for a non-myeloid malignancy AND ALL of the following: i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR less than 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND ii. Patient is being concurrently treated with chemotherapy with or without radiation (there must be a minimum of 2 additional months of planned chemotherapy) AND iii. The intent of chemotherapy is non-curative OR C. Anemia associated with chronic kidney disease in a patient NOT on dialysis AND ALL of the following: i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR 11 g/dL or less for patients stabilized on therapy (measured within the previous 4 weeks) AND ii. The rate of hemoglobin decline indicates the likelihood of requiring a RBC transfusion AND iii. The intent of therapy is to reduce the risk of alloimmunization and/or other RBC transfusion related risks OR D. Anemia due to myelodysplastic syndrome AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) OR E. Anemia resulting from zidovudine treatment of HIV infection AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) OR Initial criteria continues: see Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 month for surgery (reduce transfusion possibility), 6 months for chemo, 12 months for other

OTHER CRITERIA

F. Another indication that is supported in CMS approved compendia for the requested agent AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND 2. Patient's transferrin saturation and serum ferritin have been evaluated Drug is also subject to Part B versus Part D review.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

ERYTHROPOIETIN STIMULATING AGENTS PA - RETACRIT

MEDICATION(S)
RETACRIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. The requested agent is being prescribed for ONE of the following: A. To reduce the possibility of allogeneic blood transfusion in a surgery patient AND the patient's hemoglobin level is greater than 10 g/dL but less than or equal to 13 g/dL OR B. Anemia due to myelosuppressive chemotherapy for a non-myeloid malignancy AND ALL of the following: i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR less than 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND ii. Patient is being concurrently treated with chemotherapy with or without radiation (there must be a minimum of 2 additional months of planned chemotherapy) AND iii. The intent of chemotherapy is non-curative OR C. Anemia associated with chronic kidney disease in a patient NOT on dialysis AND ALL of the following: i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR 11 g/dL or less for patients stabilized on therapy (measured within the previous 4 weeks) AND ii. The rate of hemoglobin decline indicates the likelihood of requiring a RBC transfusion AND iii. The intent of therapy is to reduce the risk of alloimmunization and/or other RBC transfusion related risks OR D. Anemia resulting from zidovudine treatment of HIV infection AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) OR E. Another indication that is supported in CMS approved compendia for the requested agent AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND 2. Patient's transferrin saturation and serum ferritin have been evaluated Drug is also subject to Part B versus Part D review.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 month for surgery (reduce transfusion possibility), 6 months for chemo, 12 months for other

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

EYSUVIS PA

MEDICATION(S)
EYSUVIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. Patient has a diagnosis of dry eye disease AND 2. The requested agent will be used for short-term (up to two weeks) treatment AND 3. The requested dose is within FDA labeled dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 1 month

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FASENRA PA

MEDICATION(S)
FASENRA, FASENRA PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. ONE of the following: A. Patient has a diagnosis of severe asthma with an eosinophilic phenotype AND the following: i. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent OR B. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the following: i. ONE of the following: a. Patient is currently being treated with a maximally tolerated oral corticosteroid OR b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an oral corticosteroid AND 2. Patient will NOT be using the requested agent in combination with Xolair, Dupixent, or with another injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Nucala) for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of severe asthma with an eosinophilic phenotype AND the following: i. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent OR B. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the following: i. ONE of the following: a. Patient is currently being treated with maintenance therapy with oral corticosteroid OR b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to oral corticosteroid AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with Xolair, Dupixent, or with another injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Nucala) for the requested indication

AGE RESTRICTION
For diagnosis of severe asthma with an eosinophilic phenotype, patient is 6 years of age or over. For

diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA), patient is 18 years of age or over.

PRESCRIBER RESTRICTION

Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, otolaryngologist, pulmonologist, rheumatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

FENTANYL ORAL PA - FENTANYL LOZENGE

MEDICATION(S)
FENTANYL CIT OTFC 1,600 MCG, FENTANYL CITRATE OTFC 200 MCG, FENTANYL CITRATE OTFC 400 MCG, FENTANYL CITRATE OTFC 800 MCG

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FINTEPLA PA

MEDICATION(S)
FINTEPLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has a diagnosis of seizures associated with Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS) AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. ALL of the following: i. An echocardiogram assessment will be obtained before and during treatment with the requested agent, to evaluate for valvular heart disease and pulmonary arterial hypertension AND ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND iii. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
Patient is within the FDA labeled age for the requested agent

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

FLUCYTOSINE PA

MEDICATION(S)
FLUCYTOSINE 250 MG CAPSULE, FLUCYTOSINE 500 MG CAPSULE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. The requested agent will be used in combination with amphotericin B OR B. Prescriber has provided information in support of therapy without concurrent amphotericin B for the requested indication AND 3. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 10 weeks

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

FOCALIN PA

MEDICATION(S)
DEXMETHYLPHENIDATE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GAMMAGARD/GAMMAKED/GAMUNEX-C PA

MEDICATION(S)
GAMMAGARD LIQUID, GAMUNEX-C

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require ONE of the following: 1. Patient has ONE of the following diagnoses: A. Primary immunodeficiency [e.g., congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency] OR B. B-cell chronic lymphocytic leukemia OR multiple myeloma AND ONE of the following: i. Patient has a history of infections OR ii. Patient has evidence of specific antibody deficiency OR iii. Patient has hypogammaglobulinemia OR C. Idiopathic thrombocytopenia purpura AND ONE of the following: i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone), or immunosuppressants (e.g., mycophenolate)] OR ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR D. Dermatomyositis AND ONE of the following: i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone) or immunosuppressants (e.g., azathioprine)] OR ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR E. Polymyositis AND ONE of the following: i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone) or immunosuppressants (e.g., azathioprine)] OR ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR F. Severe rheumatoid arthritis AND ONE of the following: i. Patient has failed ONE conventional therapy [e.g., tumor necrosis factor antagonists (e.g., Enbrel), DMARDS (e.g., methotrexate)] OR ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR Criteria continues: see Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 6 months for indications in Other Criteria, 12 months for all others

OTHER CRITERIA
G. Myasthenia gravis (MG) AND ONE of the following: i. Patient is in acute myasthenic crisis OR ii. Patient has severe refractory MG (e.g., major functional disability/weakness) AND ONE of the following: a) Patient has failed ONE immunomodulator therapy (i.e., corticosteroid, pyridostigmine, or azathioprine) OR b) Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE immunomodulator therapy OR H. Multiple sclerosis (MS) AND BOTH of the following: i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication to TWO MS agents (e.g., dimethyl fumarate, fingolimod) OR I. Acquired von Willebrand hemophilia AND ONE of the following: i. Patient has failed ONE conventional therapy (e.g., desmopressin, von Willebrand factor replacement therapy, corticosteroids, FEIBA, or recombinant factor VIIa) OR ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR J. Refractory pemphigus vulgaris AND ONE of the following: i. Patient has failed ONE conventional immunosuppressive therapy (e.g., azathioprine, cyclophosphamide, mycophenolate, corticosteroids) OR ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional immunosuppressive therapy OR 2. ONE of the following: A. Patient has another FDA labeled indication for the requested agent OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent Indications with 6 months approval duration: Acquired von Willebrand hemophilia, Guillain-Barre Syndrome, Lambert-Eaton myasthenia syndrome, Kawasaki disease, CMV induced pneumonitis in solid organ transplant, Toxic shock syndrome due to invasive group A streptococcus, Toxic epidermal necrolysis and Stevens-Johnson syndrome Drug is also subject to Part B versus Part D review.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

GAUCHER ENZYME REPLACEMENT PA - CEREZYME

MEDICATION(S)
CEREZYME

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GAUCHER ENZYME REPLACEMENT PA - ELELYSO

MEDICATION(S)
ELELYSO

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GAUCHER ENZYME REPLACEMENT PA - VPRIV

MEDICATION(S)
VPRIV

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GAUZE PADS PA

MEDICATION(S)
GNP STERILE GAUZE PADS 2" X 2", GAUZE PADS & DRESSINGS - PADS 2 X 2, FT STERILE PADS 2" X 2"

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
This program will be implemented as a dynamic PA. Criteria for approval require BOTH of the following: 1. The requested medical supply product will be used in the delivery of insulin to the body AND 2. Patient's medication history includes use of insulin within the past 180 days

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

GROWTH HORMONE PA - OMNITROPE

MEDICATION(S)
OMNITROPE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
For Children - Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of Turner Syndrome OR B. Patient has a diagnosis of Prader-Willi Syndrome OR C. Patient has a diagnosis of panhypopituitarism AND BOTH of the following: i. Deficiencies in 3 or more pituitary axes AND ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR D. Patient has a diagnosis of growth hormone deficiency (GHD) or short stature AND BOTH of the following: i. Patient has ONE of the following: a. Height more than 2 standard deviations (SD) below the mean for age and sex OR b. Height more than 1.5 SD below the midparental height OR c. A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR d. Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over two years AND ii. Failure of at least 2 growth hormone (GH) stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab) OR E. Patient has a diagnosis of small for gestational age (SGA) AND ALL of the following: i. Patient is at least 2 years of age AND ii. Documented birth weight and/or length that is 2 or more SD below the mean for gestational age AND iii. At 24 months of age, the patient fails to manifest catch-up growth evidenced by a height that remains 2 or more SD below the mean for age and sex

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

For Children - Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the preferred agent through the plan's Prior Authorization criteria AND 2. Patient has been diagnosed with ONE of the following: A. Growth Hormone Deficiency, Short Stature OR B. Panhypopituitarism OR C. Prader-Willi Syndrome OR D. Small for Gestational Age (SGA) OR E. Turner Syndrome AND 3. ALL of the following: A. Patient does NOT have closed epiphyses AND B. Patient is being monitored for adverse effects of therapy with the requested agent AND C. Patient's height has increased or height velocity has improved since initiation or last approval of the requested agent For Adults - Criteria for initial approval require the following: 1. Patient has been diagnosed with ONE of the following: A. Childhood growth hormone deficiency (GHD) with genetic or organic origin AND ONE of the following: i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR ii. Failure of at least one growth hormone (GH) stimulation test as an adult (e.g., peak GH value of 5 mcg/L or lower after stimulation, or otherwise considered abnormal as determined by testing lab) OR B. Acquired adult GHD secondary to structural lesions or trauma AND ONE of the following: i. Patient has a diagnosis of panhypopituitarism AND BOTH of the following: a. Deficiencies in 3 or more pituitary axes AND b. Low IGF-1 level without GH replacement therapy OR ii. Patient has failed at least one growth hormone (GH) stimulation test as an adult OR C. Idiopathic GHD (adult or childhood onset) AND the patient has failed at least two growth hormone (GH) stimulation tests as an adult For Adults - Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the preferred agent through the plan's Prior Authorization criteria AND 2. Patient has been diagnosed with ONE of the following: A. Childhood growth hormone deficiency (GHD) with genetic or organic origin OR B. Acquired adult GHD secondary to structural lesions or trauma OR C. Idiopathic GHD (adult or childhood onset) AND 3. Patient is being monitored for adverse effects of therapy with the requested agent AND 4. Patient's IGF-1 level has been evaluated to confirm the appropriateness of the current dose AND 5. Patient has had clinical benefit with the requested agent (i.e., body composition, hip-to-waist ratio, cardiovascular health, bone mineral density, serum cholesterol, physical strength, or quality of life)

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

HAE PA - HAEGARDA

MEDICATION(S)
HAEGARDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed via two confirmatory tests of C1-INH antigenic level, C1-INH functional level, and C4 level as follows: a. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type I)]: decreased quantities of C4 and C1-INH (antigenic and functional level) OR b. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type II)]: decreased quantities of C4 and C1-INH function (C1-INH protein level may be normal) OR c. Hereditary angioedema (HAE) with normal C1INH [HAE-nI-C1INH (Type III)]: Normal levels of C4 and C1-INH [antigenic and functional level (at baseline and during an attack)] AND ONE of the following: i. BOTH of the following: 1. Family history of angioedema AND 2. ALL other causes of angioedema have been ruled out OR ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, plasminogen (PLG) mutation, kininogen1 mutation, heparan sulfate 3-O-sulfotransferase 6 gene mutation, or myoferlin gene mutation that is associated with the disease AND 2. Medications known to cause angioedema (e.g., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND 3. The requested agent will be used for prophylaxis against HAE attacks AND 4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for prophylaxis against HAE attacks

AGE RESTRICTION
Patient is within the FDA labeled age for the requested agent

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of hereditary angioedema (HAE) AND 3. The requested agent is being used for prophylaxis against HAE attacks AND 4. Patient has had a decrease in the frequency or severity of acute attacks or has had stabilization of disease from use of the requested agent AND 5. Patient will NOT be using the requested agent in combination with another HAE agent indicated for prophylaxis against HAE attacks

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HAE PA - ICATIBANT

MEDICATION(S)
ICATIBANT, SAJAZIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed via two confirmatory tests of C1-INH antigenic level, C1-INH functional level, and C4 level as follows: a. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type I)]: decreased quantities of C4 and C1-INH (antigenic and functional level) OR b. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type II)]: decreased quantities of C4 and C1-INH function (C1-INH protein level may be normal) OR c. Hereditary angioedema (HAE) with normal C1INH [HAE-nI-C1INH (Type III)]: Normal levels of C4 and C1-INH [antigenic and functional level (at baseline and during an attack)] AND ONE of the following: i. BOTH of the following: 1. Family history of angioedema AND 2. ALL other causes of angioedema have been ruled out OR ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, plasminogen (PLG) mutation, kininogen1 mutation, heparan sulfate 3-O-sulfotransferase 6 gene mutation, or myoferlin gene mutation that is associated with the disease AND 2. Medications known to cause angioedema (e.g., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND 3. The requested agent will be used to treat acute HAE attacks AND 4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks

AGE RESTRICTION
Patient is within the FDA labeled age for the requested agent

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of hereditary angioedema (HAE) AND 3. The requested agent will be used to treat acute HAE attacks AND 4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks AND 5. Patient has had a decrease in the frequency or severity of acute attacks or stabilization of disease from use of the requested agent

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HIGH RISK MEDICATION PA - ALL STARTS

MEDICATION(S)

CYPROHEPTADINE 4 MG TABLET, DICYCLOMINE 10 MG CAPSULE, DICYCLOMINE 10 MG/5 ML SOLN, DICYCLOMINE 20 MG TABLET, DIPHENOXYLATE-ATROP 2.5-0.025, HYDROXYZINE 10 MG/5 ML SOLN, HYDROXYZINE 10 MG/5 ML SYRUP, HYDROXYZINE 50 MG/25 ML CUP, HYDROXYZINE HCL 10 MG TABLET, HYDROXYZINE HCL 25 MG TABLET, HYDROXYZINE HCL 50 MG TABLET, HYDROXYZINE PAM 25 MG CAP, HYDROXYZINE PAM 50 MG CAP, PROMETHAZINE 12.5 MG SUPPOS, PROMETHAZINE 12.5 MG TABLET, PROMETHAZINE 25 MG SUPPOSITORY, PROMETHAZINE 25 MG TABLET, PROMETHAZINE 50 MG TABLET, PROMETHEGAN 12.5 MG SUPPOS, PROMETHEGAN 25 MG SUPPOSITORY, SCOPOLAMINE, TRIHEXYPHENIDYL 2 MG TABLET, TRIHEXYPHENIDYL 5 MG TABLET

PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

PA does NOT apply to patients less than 65 years of age. Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND 2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND 3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

IMIQUIMOD PA

MEDICATION(S)
IMIQUIMOD 5% CREAM PACKET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has ONE of the following diagnoses: A. Actinic keratosis OR B. Superficial basal cell carcinoma OR C. External genital and/or perianal warts/condyloma acuminata OR D. Squamous cell carcinoma OR E. Basal cell carcinoma OR F. Another indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
4 months for Actinic keratosis, other diagnoses - see Other Criteria

OTHER CRITERIA
2 months for Superficial basal cell carcinoma, Squamous cell carcinoma, or Basal cell carcinoma 4 months for External genital and/or perianal warts/condyloma acuminata 12 months for All other diagnoses

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

INBRIJA PA

MEDICATION(S)
INBRIJA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. The requested agent will be used for intermittent treatment of OFF episodes in patients with Parkinson's disease AND 2. The requested agent will be used in combination with carbidopa/levodopa

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INGREZZA PA

MEDICATION(S)
INGREZZA, INGREZZA INITIATION PK(TARDIV), INGREZZA SPRINKLE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of the following: A. Patient has a diagnosis of chorea associated with Huntington's disease AND BOTH of the following: i. ONE of the following: 1. Patient does NOT have a current diagnosis of depression OR 2. Patient has a current diagnosis of depression and is being treated for depression AND ii. ONE of the following: 1. Patient does NOT have a diagnosis of passive suicidal ideation and/or behavior OR 2. Patient has a diagnosis of passive suicidal ideation and/or behavior and must NOT be actively suicidal OR B. Patient has a diagnosis of tardive dyskinesia AND ONE of the following: i. Prescriber has reduced the dose of or discontinued any medications known to cause tardive dyskinesia (i.e., dopamine receptor blocking agents) OR ii. Prescriber has provided clinical rationale indicating that a reduced dose or discontinuation of any medications known to cause tardive dyskinesia is not appropriate

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

INJECTABLE ONCOLOGY PA

MEDICATION(S)
FIRMAGON

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. ALL of the following: i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND ii. ONE of the following: a. The requested agent is FDA labeled or supported by CMS approved compendia as first-line therapy for the requested indication OR b. Patient has tried appropriate FDA labeled or CMS approved compendia supported therapy that are indicated as first-line therapy for the requested indication OR c. Patient has an intolerance or hypersensitivity to the first-line therapy for the requested indication OR d. Patient has an FDA labeled contraindication to the first-line therapy for the requested indication AND iii. Patient does NOT have any FDA labeled contraindications to the requested agent AND iv. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines May also be subject to Part B versus Part D review.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

INSULIN PEN NEEDLE PA

MEDICATION(S)
DROPLET MICRON PEN NEEDLE, DROPLET PEN NEEDLE, EASY COMFORT PEN NEEDLE, INSULIN PEN NEEDLE, INSUPEN PEN NEEDLE, NANO 2ND GEN PEN NEEDLE, NANO PEN NEEDLE, PEN NEEDLE, ULTRA-FINE PEN NEEDLE, UNIFINE OTC PEN NEEDLE, UNIFINE PENTIPS, UNIFINE PENTIPS PLUS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
This program will be implemented as a dynamic PA. Criteria for approval require BOTH of the following: 1. The requested medical supply product will be used in the delivery of insulin to the body AND 2. Patient's medication history includes use of insulin within the past 180 days

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

INSULIN SYRINGE_NEEDLE PA

MEDICATION(S)

AUTOSHIELD DUO PEN NEEDLE, DROPLET 0.3 ML 29G 12.7MM(1/2), DROPLET 0.3 ML 30G 12.7MM(1/2), DROPLET INS 0.3ML 30G 8MM(1/2), DROPLET INS 0.3ML 31G 6MM(1/2), DROPLET INS 0.3ML 31G 8MM(1/2), DROPLET INS 0.5 ML 29G 12.7MM, DROPLET INS 0.5 ML 30G 12.7MM, DROPLET INS SYR 0.5 ML 31G 6MM, DROPLET INS SYR 0.5 ML 31G 8MM, DROPLET INS SYR 0.5ML 30G 8MM, DROPLET INS SYR 1 ML 30G 8MM, DROPLET INS SYR 1 ML 31G 6MM, DROPLET INS SYR 1 ML 31G 8MM, DROPLET INS SYR 1ML 29G 12.7MM, DROPLET INS SYR 1ML 30G 12.7MM, EASY COMFORT INSULIN SYRINGE, INSULIN PEN NEEDLE, INSULIN SYR 0.5 ML 28G 12.7MM, INSULIN SYRINGE 1 ML 27G 16MM, INSULIN SYRINGE 1ML 28G 12.7MM, INSULIN SYRINGE (DISP) U-100 0.3 ML, INSULIN SYRINGE (DISP) U-100 1 ML, INSULIN SYRINGE (DISP) U-100 1/2 ML, NEEDLES, INSULIN DISP., SAFETY, TRUE COMFORT SAFETY PEN NEEDLE, ULTRA-FINE INSULIN SYRINGE

PA INDICATION INDICATOR

1 - All FDA-Approved Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

This program will be implemented as a dynamic PA. Criteria for approval require BOTH of the following: 1. The requested medical supply product will be used in the delivery of insulin to the body AND 2. Patient's medication history includes use of insulin within the past 180 days

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

IRON CHELATING AGENTS PA - EXJADE

MEDICATION(S)
DEFERASIROX 125 MG TB FOR SUSP, DEFERASIROX 250 MG TB FOR SUSP, DEFERASIROX 500 MG TB FOR SUSP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. ONE of the following: A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome AND ONE of the following: i. A liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight OR ii. A serum ferritin greater than 300 mcg/L OR iii. MRI confirmation of iron deposition OR B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND 2. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome OR B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication

AGE RESTRICTION
Patient is within the FDA labeled age for the requested agent for the requested indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

IRON CHELATING AGENTS PA - JADENU

MEDICATION(S)
DEFERASIROX 180 MG GRANULE PKT, DEFERASIROX 180 MG TABLET, DEFERASIROX 360 MG GRANULE PKT, DEFERASIROX 360 MG TABLET, DEFERASIROX 90 MG GRANULE PKT, DEFERASIROX 90 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. ONE of the following: A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome AND ONE of the following: i. A liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight OR ii. A serum ferritin greater than 300 mcg/L OR iii. MRI confirmation of iron deposition OR B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND 2. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome OR B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication

AGE RESTRICTION
Patient is within the FDA labeled age for the requested agent for the requested indication

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

ISOTRETINOIN PA

MEDICATION(S)
ACCUTANE, AMNESTEEM, CLARAVIS, ISOTRETINOIN, ZENATANE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 3. Patient has had clinical benefit with the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be 6 months for initial, 12 months for renewal

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

IVERMECTIN CREAM PA

MEDICATION(S)
IVERMECTIN 1% CREAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IVERMECTIN TABLET PA

MEDICATION(S)
IVERMECTIN 3 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 4 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

JYNARQUE PA

MEDICATION(S)
JYNARQUE 15 MG TABLET, JYNARQUE 30 MG TABLET, TOLVAPTAN 15 MG-15 MG TABLET, TOLVAPTAN 30 MG-15 MG TABLET, TOLVAPTAN 45 MG-15 MG TABLET, TOLVAPTAN 60 MG-30 MG TABLET, TOLVAPTAN 90 MG-30 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed by ONE of the following: A. Ultrasound OR B. MRI or CT scan OR C. Genetic testing AND 2. Patient is at risk of rapid disease progression AND 3. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD) AND 3. Patient has had clinical benefit with the requested agent AND 4. The requested dose is within FDA labeled dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., nephrologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

KALYDECO PA

MEDICATION(S)
KALYDECO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of cystic fibrosis AND 2. ONE of the following: A. Patient has ONE of the CFTR gene mutations or a mutation in the CFTR gene that is responsive based on in vitro data, as indicated in the FDA label, confirmed by genetic testing OR B. Patient has another CFTR gene mutation(s) that is responsive to the requested agent, as indicated in the FDA label, confirmed by genetic testing AND 3. Patient is NOT homozygous for the F508del mutation AND 4. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of cystic fibrosis AND 3. Patient has had improvement or stabilization with the requested agent [e.g., improvement in FEV1 from baseline, increase in weight/BMI, improvement from baseline Cystic Fibrosis Questionnaire-Revised (CFQ-R) Respiratory Domain score, improvements in respiratory symptoms (cough, sputum production, and difficulty breathing), and/or reduced number of pulmonary exacerbations] AND 4. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication

AGE RESTRICTION
Patient is within the FDA labeled age for the requested agent

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cystic fibrosis, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

KERENDIA PA

MEDICATION(S)
KERENDIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

L-GLUTAMINE PA

MEDICATION(S)
L-GLUTAMINE 5 GRAM POWDER PKT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of sickle cell disease AND 2. Patient is using the requested agent to reduce the acute complications of sickle cell disease AND 3. ONE of the following: A. Patient has tried and had an inadequate response to maximally tolerated dose of hydroxyurea OR B. Patient has an intolerance or hypersensitivity to hydroxyurea OR C. Patient has an FDA labeled contraindication to hydroxyurea Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of sickle cell disease AND 3. Patient is using the requested agent to reduce the acute complications of sickle cell disease AND 4. Patient has had clinical benefit with the requested agent

AGE RESTRICTION
Patient is within the FDA labeled age for the requested agent

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

LEUPROLIDE PA

MEDICATION(S)
ELIGARD, LEUPROLIDE 2WK 14 MG/2.8 ML KT, LEUPROLIDE 2WK 14 MG/2.8 ML VL, LEUPROLIDE DEPOT, LUPRON DEPOT 3.75 MG KIT, LUPRON DEPOT 7.5 MG KIT, LUPRON DEPOT 3.75MG (LUPANETA), LUPRON DEPOT-PED 11.25 MG 3MO, LUPRON DEPOT-PED 45 MG 6MO KIT, LUPRON DEPOT-PED 7.5 MG KIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. BOTH of the following: i. Patient is NOT currently being treated with the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

LIDOCAINE TOPICAL PA - LIDOCAINE OINTMENT

MEDICATION(S)
LIDOCAINE 5% OINTMENT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. The requested agent will be used for ONE of the following: A. Anesthesia of accessible mucous membranes of the oropharynx OR B. Anesthetic lubricant for intubation OR C. Temporary relief of pain associated with minor burns, including sunburn, abrasions of the skin, and insect bites OR D. Another indication that is supported in CMS approved compendia for the requested agent AND ONE of the following: i. Patient has tried and had an inadequate response to a conventional therapy [e.g., gabapentin, pregabalin, oral prescription NSAID (non-steroidal anti-inflammatory drug)] for the requested indication OR ii. Patient has an intolerance or hypersensitivity to a conventional therapy OR iii. Patient has an FDA labeled contraindication to a conventional therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

LIDOCAINE TOPICAL PA - LIDOCAINE PATCH

MEDICATION(S)
DERMACINRX LIDOCAN, LIDOCAINE 5% PATCH, LIDOCAN III, LIDOCAN IV, LIDOCAN V

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has ONE of the following diagnoses: A. Pain associated with postherpetic neuralgia (PHN) OR B. Pain associated with diabetic neuropathy OR C. Neuropathic pain associated with cancer, or cancer treatment OR D. Another diagnosis that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. Patient has tried and had an inadequate response to a conventional therapy [e.g., gabapentin, pregabalin, oral prescription NSAID (non-steroidal anti-inflammatory drug)] for the requested indication OR B. Patient has an intolerance or hypersensitivity to a conventional therapy OR C. Patient has an FDA labeled contraindication to a conventional therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

LIDOCAINE TOPICAL PA - LIDOCAINE SOLUTION

MEDICATION(S)
LIDOCAINE HCL 4% SOLUTION

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. The requested agent will be used for ONE of the following: A. Topical anesthesia of accessible mucous membranes of the oral and nasal cavities OR B. Topical anesthesia of accessible mucous membranes of proximal portions of the digestive tract OR C. Another indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LIDOCAINE TOPICAL PA - LIDOCAINE/PRILOCAINE CREAM

MEDICATION(S)
LIDOCAINE-PRILOCAINE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. The requested agent will be used for ONE of the following: A. Local analgesia on normal intact skin OR B. Topical anesthetic for dermal procedures OR C. Adjunctive anesthesia prior to local anesthetic infiltration in adult male genital skin OR D. Anesthesia for minor procedures on female external genitalia OR E. Another indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LIDOCAINE TOPICAL PA - ZTLIDO

MEDICATION(S)
ZTLIDO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. Patient has ONE of the following diagnoses: A. Pain associated with postherpetic neuralgia (PHN) OR B. Neuropathic pain associated with cancer, or cancer treatment OR C. Another diagnosis that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. Patient has tried and had an inadequate response to generic lidocaine 5% patch OR B. Patient has an intolerance or hypersensitivity to generic lidocaine 5% patch OR C. Patient has an FDA labeled contraindication to generic lidocaine 5% patch AND 3. ONE of the following: A. Patient has tried and had an inadequate response to a conventional therapy [e.g., gabapentin, pregabalin, oral prescription NSAID (non-steroidal anti-inflammatory drug)] for the requested indication OR B. Patient has an intolerance or hypersensitivity to a conventional therapy OR C. Patient has an FDA labeled contraindication to a conventional therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

LINEZOLID PA

MEDICATION(S)
LINEZOLID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND ONE of the following: a. The requested agent is prescribed by an infectious disease specialist or the prescriber has consulted with an infectious disease specialist on treatment of this patient OR b. Patient has a documented infection due to vancomycin-resistant Enterococcus faecium OR c. Patient has a diagnosis of pneumonia caused by Staphylococcus aureus or Streptococcus pneumoniae AND ONE of the following: i. Patient has a documented infection that is resistant to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole, OR that is resistant to vancomycin OR ii. Patient has an intolerance or hypersensitivity to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR iii. Patient has an FDA labeled contraindication to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR iv. Patient has an intolerance or hypersensitivity to vancomycin OR v. Patient has an FDA labeled contraindication to vancomycin OR d. Patient has a documented skin and skin structure infection, including diabetic foot infections, caused by Staphylococcus aureus, Streptococcus pyogenes, or Streptococcus agalactiae AND ONE of the following: i. Patient has a documented infection that is resistant to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole, OR that is resistant to vancomycin at the site of infection OR ii. Patient has an intolerance or hypersensitivity to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR iii. Patient has an FDA labeled contraindication to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR Criteria continues: see Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 3 months

OTHER CRITERIA
iv. Patient has an intolerance or hypersensitivity to vancomycin OR v. Patient has an FDA labeled contraindication to vancomycin AND 2. Patient will NOT be using the requested agent in combination with Sivextro (tedizolid) for the same infection AND 3. The requested dose is within FDA labeled dosing for the requested indication

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LUMRYZ PA

MEDICATION(S)
LUMRYZ, LUMRYZ STARTER PACK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of narcolepsy with cataplexy OR B. BOTH of the following: i. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness AND ii. ONE of the following: a. Patient is between the ages of 7 and less than 18 years OR b. BOTH of the following: 1. Patient is 18 years of age or over AND 2. ONE of the following: a) Patient has tried and had an inadequate response to modafinil or armodafinil OR b) Patient has an intolerance or hypersensitivity to modafinil or armodafinil OR c) Patient has an FDA labeled contraindication to modafinil or armodafinil OR C. Patient has another indication that is supported in CMS approved compendia for the requested agent Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of narcolepsy with cataplexy OR B. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness OR C. Patient has another indication that is supported in CMS approved compendia for the requested agent AND 3. Patient has had clinical benefit with the requested agent

AGE RESTRICTION
For diagnosis of narcolepsy with cataplexy, patient is 7 years of age or over. For diagnosis of narcolepsy with excessive daytime sleepiness, patient is 7 years of age or over.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

MAVYRET PA

MEDICATION(S)
MAVYRET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. ONE of the following: A. Patient has a diagnosis of hepatitis C confirmed by serological markers OR B. Patient is a hepatitis C virus (HCV) - uninfected solid organ transplant recipient AND BOTH of the following: i. Patient received an HCV - viremic donor organ AND ii. The requested agent is being used for prophylaxis AND 2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND 3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND 4. The requested dose is within FDA labeled dosing or supported in AASLD/IDSA guideline dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

MEMANTINE ER PA

MEDICATION(S)
MEMANTINE HCL ER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PA does NOT apply to patients greater than or equal to 30 years of age Criteria for approval require the following: 1. Patient is younger than 30 years of age AND ONE of the following: A. Patient has a diagnosis of moderate to severe dementia of the Alzheimer's type OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MEMANTINE PA

MEDICATION(S)
MEMANTINE 5-10 MG TITRATION PK, MEMANTINE HCL 10 MG TABLET, MEMANTINE HCL 10 MG/5 ML CUP, MEMANTINE HCL 2 MG/ML SOLUTION, MEMANTINE HCL 5 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PA does NOT apply to patients greater than or equal to 30 years of age Criteria for approval require the following: 1. Patient is younger than 30 years of age AND ONE of the following: A. Patient has a diagnosis of moderate to severe dementia of the Alzheimer's type OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

METHYLIN PA

MEDICATION(S)
METHYLPHENIDATE 10 MG/5 ML SOL, METHYLPHENIDATE 5 MG/5 ML SOLN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

METHYLPHENIDATE ER TABLET PA

MEDICATION(S)
METHYLPHENIDATE ER 10 MG TAB, METHYLPHENIDATE ER 20 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MIEBO PA

MEDICATION(S)
MIEBO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MIFEPRISTONE PA

MEDICATION(S)
MIFEPRISTONE 300 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of Cushing's syndrome AND 2. ONE of the following: A. Patient has type 2 diabetes mellitus OR B. Patient has glucose intolerance as defined by a 2-hour glucose tolerance test plasma glucose value of 140-199 mg/dL AND 3. ONE of the following: A. Patient had an inadequate response to surgical resection OR B. Patient is NOT a candidate for surgical resection Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of Cushing's syndrome AND 3. Patient has had clinical benefit with the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

MIGRANAL PA

MEDICATION(S)
DIHYDROERGOTAMINE 4 MG/ML SPRY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. The requested agent will be used for the treatment of acute migraine with or without aura AND 2. ONE of the following: A. Patient has tried and had an inadequate response to TWO triptan agents with differing active ingredients (e.g., sumatriptan, rizatriptan) OR B. Patient has an intolerance or hypersensitivity to TWO triptan agents with differing active ingredients OR C. Patient has an FDA labeled contraindication to TWO triptan agents with differing active ingredients AND 3. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, acute CGRP) Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. The requested agent will be used for the treatment of acute migraine with or without aura AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, acute CGRP)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

MODAFINIL PA

MEDICATION(S)
MODAFINIL 100 MG TABLET, MODAFINIL 200 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another target agent (i.e., armodafinil)

AGE RESTRICTION
Patient is 17 years of age or over

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MOUNJARO PA

MEDICATION(S)
MOUNJARO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Requested agent will be used for weight loss alone

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR C. ALL of the following: i. Patient does NOT have any FDA labeled contraindications to the requested agent AND ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

MS PA - AVONEX

MEDICATION(S)
AVONEX 30 MCG/0.5 ML SYRINGE, AVONEX (4 PACK), AVONEX PEN (4 PACK)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

MS PA - BETASERON

MEDICATION(S)
BETASERON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

MS PA - DIMETHYL FUMARATE

MEDICATION(S)
DIMETHYL FUMARATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

MS PA - FINGOLIMOD

MEDICATION(S)
FINGOLIMOD

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication AND 3. Prescriber has performed an electrocardiogram within 6 months prior to initiating treatment Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

MS PA - GLATIRAMER

MEDICATION(S)
GLATIRAMER ACETATE, GLATOPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

MS PA - KESIMPTA

MEDICATION(S)
KESIMPTA PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

MS PA - PLEGRIDY

MEDICATION(S)
PLEGRIDY, PLEGRIDY PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

MS PA - VUMERITY

MEDICATION(S)
VUMERITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

NUEDEXTA PA

MEDICATION(S)
NUEDEXTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of the following: A. Patient has a diagnosis of pseudobulbar affect OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NUPLAZID PA

MEDICATION(S)
NUPLAZID 10 MG TABLET, NUPLAZID 34 MG CAPSULE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NURTEC PA

MEDICATION(S)
NURTEC ODT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has a diagnosis of migraine AND 2. ONE of the following: A. The requested agent is being used for the treatment of acute migraine with or without aura AND BOTH of the following: i. ONE of the following: a. Patient has tried and had an inadequate response to a triptan (e.g., sumatriptan, rizatriptan) agent OR b. Patient has an intolerance, or hypersensitivity to a triptan OR c. Patient has an FDA labeled contraindication to a triptan AND ii. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., 5HT-1F, ergotamine, acute CGRP) OR B. The requested agent is being used for migraine prophylaxis AND BOTH of the following: i. Patient has 4 or more migraine headache days per month AND ii. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of migraine AND 3. ONE of the following: A. The requested agent is being used for the treatment of acute migraine with or without aura AND BOTH of the following: i. Patient has had clinical benefit with the requested agent AND ii. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., 5HT-1F, ergotamine, acute CGRP) OR B. The requested agent is being used for migraine prophylaxis AND BOTH of the following: i. Patient has had clinical benefit with the requested agent AND ii. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OFEV PA

MEDICATION(S)
OFEV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF) AND ii. Patient has no known explanation for interstitial lung disease (ILD) or pulmonary fibrosis (e.g., radiation, drugs, metal dusts, sarcoidosis, or any connective tissue disease known to cause ILD) OR B. BOTH of the following: i. Patient has a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) AND ii. Patient's diagnosis has been confirmed on high-resolution computed tomography (HRCT) or chest radiography scans OR C. BOTH of the following: i. Patient has a diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype AND ii. Patient's diagnosis has been confirmed on high-resolution computed tomography (HRCT) Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of ONE of the following: A. Idiopathic pulmonary fibrosis (IPF) OR B. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) OR C. Chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype AND 3. Patient has had clinical benefit with the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., pathologist, pulmonologist, radiologist, rheumatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

OMNIPOD PA

MEDICATION(S)
OMNIPOD 5 (G6/LIBRE 2 PLUS), OMNIPOD 5 DEXG7G6 INTRO(GEN 5), OMNIPOD 5 DEXG7G6 PODS (GEN 5), OMNIPOD 5 G6-G7 INTRO KT(GEN5), OMNIPOD 5 G6-G7 PODS (GEN 5), OMNIPOD 5 INTRO(G6/LIBRE2PLUS), OMNIPOD CLASSIC PODS (GEN 3), OMNIPOD DASH INTRO KIT (GEN 4), OMNIPOD DASH PDM KIT (GEN 4), OMNIPOD DASH PODS (GEN 4), OMNIPOD GO PODS

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OPHTHALMIC IMMUNOMODULATORS PA - XIIDRA

MEDICATION(S)
XIIDRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OPIOIDS ER PA - BUPRENORPHINE PAIN

MEDICATION(S)
BELBUCA, BUPRENORPHINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of the following: A. Patient has a diagnosis of cancer-related pain OR B. Patient has a diagnosis of pain due to sickle cell disease OR C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following: i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR iii. ALL of the following: a. Prescriber has completed a formal, consultative evaluation including BOTH of the following: 1. Diagnosis AND 2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis AND b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND d. ONE of the following: 1. Patient's medication history includes use of an immediate-acting opioid OR 2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR 3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND f. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

OPIOIDS ER PA - FENTANYL PATCH

MEDICATION(S)
FENTANYL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of the following: A. Patient has a diagnosis of cancer-related pain OR B. Patient has a diagnosis of pain due to sickle cell disease OR C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following: i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR iii. ALL of the following: a. Prescriber has completed a formal, consultative evaluation including BOTH of the following: 1. Diagnosis AND 2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis AND b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND d. ONE of the following: 1. Patient's medication history includes use of an immediate-acting opioid OR 2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR 3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND f. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

OPIOIDS ER PA - MORPHINE

MEDICATION(S)
MORPHINE SULF ER 100 MG TABLET, MORPHINE SULF ER 15 MG TABLET, MORPHINE SULF ER 200 MG TABLET, MORPHINE SULF ER 30 MG TABLET, MORPHINE SULF ER 60 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of the following: A. Patient has a diagnosis of cancer-related pain OR B. Patient has a diagnosis of pain due to sickle cell disease OR C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following: i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR iii. ALL of the following: a. Prescriber has completed a formal, consultative evaluation including BOTH of the following: 1. Diagnosis AND 2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis AND b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND d. ONE of the following: 1. Patient's medication history includes use of an immediate-acting opioid OR 2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR 3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND f. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

OPIOIDS ER PA - TRAMADOL

MEDICATION(S)
TRAMADOL HCL ER 100 MG TABLET, TRAMADOL HCL ER 200 MG TABLET, TRAMADOL HCL ER 300 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of the following: A. Patient has a diagnosis of cancer-related pain OR B. Patient has a diagnosis of pain due to sickle cell disease OR C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following: i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR iii. ALL of the following: a. Prescriber has completed a formal, consultative evaluation including BOTH of the following: 1. Diagnosis AND 2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis AND b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND d. ONE of the following: 1. Patient's medication history includes use of an immediate-acting opioid OR 2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR 3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND f. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

ORKAMBI PA

MEDICATION(S)
ORKAMBI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of cystic fibrosis AND 2. ONE of the following: A. Patient has the presence of the F508del mutation on both alleles (homozygous) of the CFTR gene confirmed by genetic testing OR B. Patient has another CFTR gene mutation(s) that is responsive to the requested agent, as indicated in the FDA label, confirmed by genetic testing AND 3. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of cystic fibrosis AND 3. Patient has had improvement or stabilization with the requested agent [e.g., improvement in FEV1 from baseline, increase in weight/BMI, improvement from baseline Cystic Fibrosis Questionnaire-Revised (CFQ-R) Respiratory Domain score, improvements in respiratory symptoms (cough, sputum production, and difficulty breathing), and/or reduced number of pulmonary exacerbations] AND 4. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication

AGE RESTRICTION
Patient is within the FDA labeled age for the requested agent

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cystic fibrosis, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

OTEZLA PA

MEDICATION(S)
OTEZLA 10-20 MG STARTER 28 DAY, OTEZLA 10-20-30MG START 28 DAY, OTEZLA 20 MG TABLET, OTEZLA 30 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. Patient has ONE of the following diagnoses: 1. Plaque psoriasis OR 2. Active psoriatic arthritis AND ii. ONE of the following: 1. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR 2. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR 3. Patient's medication history indicates use of a biologic immunomodulator agent for the same FDA labeled indication OR 4. Patient has tried and had an inadequate response to at least ONE conventional prerequisite agent for the requested indication OR 5. Patient has an intolerance or hypersensitivity to at least ONE conventional prerequisite agent for the requested indication OR 6. Patient has an FDA labeled contraindication to at least ONE conventional prerequisite agent for the requested indication OR B. Patient has a diagnosis of oral ulcers associated with Behcet's disease (BD) Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has ONE of the following diagnoses: A. Plaque psoriasis OR B. Active psoriatic arthritis OR C. Oral ulcers associated with Behcet's disease (BD) AND 3. Patient has had clinical benefit with the requested agent (slowing of disease progression or decrease in symptom severity and/or frequency)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Formulary conventional agent required for diagnoses of plaque psoriasis or active psoriatic arthritis Formulary conventional agents for plaque psoriasis include cyclosporine, methotrexate, tazarotene, topical calcitriol, or topical corticosteroids Formulary conventional agents for active psoriatic arthritis include cyclosporine, leflunomide, methotrexate, or sulfasalazine NO prerequisites are required for a diagnosis of oral ulcers associated with Behcet's disease (BD)

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OZEMPIC PA

MEDICATION(S)
OZEMPIC 0.25-0.5 MG/DOSE PEN, OZEMPIC 1 MG/DOSE (4 MG/3 ML), OZEMPIC 2 MG/DOSE (8 MG/3 ML)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Requested agent will be used for weight loss alone

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR C. ALL of the following: i. Patient does NOT have any FDA labeled contraindications to the requested agent AND ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

PANRETIN PA

MEDICATION(S)
PANRETIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. ALL of the following: i. ONE of the following: 1. BOTH of the following: a. Patient has a diagnosis of cutaneous lesions associated with AIDS-related Kaposi's sarcoma (KS) AND b. Patient does NOT require systemic anti-Kaposi's sarcoma therapy OR 2. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, dermatologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND iii. Patient does NOT have any FDA labeled contraindications to the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

PART D VS PART B

MEDICATION(S)

ACETYLCYSTEINE 10% VIAL, ACETYLCYSTEINE 20% VIAL, ACYCLOVIR 1,000 MG/20 ML VIAL, ACYCLOVIR 500 MG/10 ML VIAL, ALBUTEROL 2.5 MG/0.5 ML SOL, ALBUTEROL SUL 0.63 MG/3 ML SOL, ALBUTEROL SUL 1.25 MG/3 ML SOL, ALBUTEROL SUL 2.5 MG/3 ML SOLN, AMPHOTERICIN B, AMPHOTERICIN B LIPOSOME, APREPITANT, ATGAM, AZATHIOPRINE 50 MG TABLET, BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP, CROMOLYN 20 MG/2 ML NEB SOLN, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 25 MG TABLET, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG TABLET, CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE MODIFIED, DRONABINOL, ENGERIX-B ADULT, ENGERIX-B PEDIATRIC-ADOLESCENT, ENVARSUS XR, EVEROLIMUS 0.25 MG TABLET, EVEROLIMUS 0.5 MG TABLET, EVEROLIMUS 0.75 MG TABLET, EVEROLIMUS 1 MG TABLET, GENGRAF, GRANISETRON HCL 1 MG TABLET, HEPLISAV-B 20 MCG/0.5 ML SYRNG, HUMULIN R U-500, HYDROMORPHONE 10 MG/ML AMPULE, HYDROMORPHONE 10 MG/ML VIAL, HYDROMORPHONE 50 MG/5 ML AMP, HYDROMORPHONE 50 MG/5 ML VIAL, HYDROMORPHONE 500 MG/50 ML VL, IMOVAX RABIES VACCINE, INTRALIPID 20% IV FAT EMUL, IPRATROPIUM BR 0.02% SOLN, IPRATROPIUM-ALBUTEROL, JYNNEOS, JYNNEOS (NATIONAL STOCKPILE), MYCOPHENOLATE 200 MG/ML SUSP, MYCOPHENOLATE 250 MG CAPSULE, MYCOPHENOLATE 500 MG TABLET, MYCOPHENOLIC ACID, MYHIBBIN, NUTRILIPID, PENTAMIDINE 300 MG INHAL POWDR, PROGRAF 0.2 MG GRANULE PACKET, PROGRAF 1 MG GRANULE PACKET, PULMOZYME, RABAVERT, RECOMBIVAX HB, SIROLIMUS 0.5 MG TABLET, SIROLIMUS 1 MG TABLET, SIROLIMUS 1 MG/ML ORAL SOLN, SIROLIMUS 1 MG/ML SOLUTION, SIROLIMUS 2 MG TABLET, TACROLIMUS 0.5 MG CAPSULE (IR), TACROLIMUS 1 MG CAPSULE (IR), TACROLIMUS 5 MG CAPSULE (IR), TENIVAC, THYMOGLOBULIN, TRAVASOL, TROPHAMINE, XATMEP

DETAILS

This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

PEGYLATED INTERFERON PA

MEDICATION(S)
PEGASYS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of the following: A. Patient has a diagnosis of chronic hepatitis B AND BOTH of the following: i. The chronic hepatitis B infection has been confirmed by serological markers AND ii. Patient has NOT been administered the requested agent for more than 48 weeks for the treatment of chronic hepatitis B OR B. BOTH of the following: i. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND ii. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling for the patient's diagnosis and genotype OR C. Patient has an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months for all other diagnoses. For hep B, hep C see Other Criteria

OTHER CRITERIA
No prior peginterferon alfa use, approve 48 weeks for hepatitis B infection. Prior peginterferon alfa use, approve remainder of 48 weeks of total therapy for hepatitis B infection Duration of therapy for hepatitis C: Based on FDA approved labeling

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

PIRFENIDONE PA

MEDICATION(S)
PIRFENIDONE 267 MG CAPSULE, PIRFENIDONE 267 MG TABLET, PIRFENIDONE 801 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF) AND 2. Patient has no known explanation for interstitial lung disease (ILD) or pulmonary fibrosis (e.g., radiation, drugs, metal dusts, sarcoidosis, or any connective tissue disease known to cause ILD) Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF) AND 3. Patient has had clinical benefit with the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., pathologist, pulmonologist, radiologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

POSACONAZOLE PA

MEDICATION(S)
POSACONAZOLE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of oropharyngeal candidiasis AND ONE of the following: i. Patient has tried and had an inadequate response to fluconazole or an alternative antifungal agent OR ii. Patient has an intolerance or hypersensitivity to fluconazole or an alternative antifungal agent OR iii. Patient has an FDA labeled contraindication to fluconazole or an alternative antifungal agent OR B. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida AND patient is severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR C. Patient has a diagnosis of invasive Aspergillus AND ONE of the following: i. Patient has tried and had an inadequate response to an alternative antifungal agent OR ii. Patient has an intolerance or hypersensitivity to an alternative antifungal agent OR iii. Patient has an FDA labeled contraindication to an alternative antifungal agent OR D. Patient has another indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Approval will be 1 month for oropharyngeal candidiasis, 6 months for all other indications

OTHER CRITERIA

Criteria for renewal approval require BOTH of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida and patient continues to be severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR B. Patient has a diagnosis of invasive Aspergillus AND patient has continued indicators of active disease (e.g., biomarkers in serum assay, microbiologic cultures, radiographic evidence) OR C. BOTH of the following: i. Patient has a diagnosis of oropharyngeal candidiasis AND ii. Patient has had clinical benefit with the requested agent OR D. BOTH of the following: i. Patient has another indication that is supported in CMS approved compendia for the requested agent AND ii. Patient has had clinical benefit with the requested agent

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

PROLIA PA

MEDICATION(S)
PROLIA

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Osteopenia (osteoporosis prophylaxis)

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of: 1. ONE of: A. Patient's (pt) sex is male or the pt is postmenopausal with a diagnosis of osteoporosis AND BOTH of: i. Pt's diagnosis was confirmed by ONE of: 1. A fragility fracture in the hip or spine OR 2. A T-score of -2.5 or lower OR 3. A T-score of -1.0 to -2.5 AND ONE of: a. A fragility fracture of the proximal humerus, pelvis, or distal forearm OR b. A FRAX 10-year probability for major osteoporotic fracture of 20% or greater OR c. A FRAX 10-year probability of hip fracture of 3% or greater AND ii. ONE of: 1. Pt is at a very high fracture risk as defined by ONE of: a. Pt had a recent fracture (within the past 12 months) OR b. Pt had fractures while on FDA approved osteoporosis therapy OR c. Pt has had multiple fractures OR d. Pt had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR e. Pt has a very low T-score (less than -3.0) OR f. Pt is at high risk for falls or has a history of injurious falls OR g. Pt has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm OR 2. ONE of: a. Pt's medication history includes use of a bisphosphonate OR b. Pt has an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate OR B. Pt is requesting the agent for osteopenia (osteoporosis prophylaxis) AND ALL of: i. ONE of: 1. Pt's sex is male and the pt is 50 years of age or over OR 2. Pt is postmenopausal AND ii. Pt has a T-score between -1.0 to -2.50 AND iii. ONE of: a. A fragility fracture of the proximal humerus, pelvis, or distal forearm OR b. 10-year probability of a hip fracture 3% and greater per FRAX OR c. 10-year probability of a major OP-related fracture 20% and greater per FRAX AND iv. ONE of: a. Pt's medication history includes use of a bisphosphonate OR Criteria continues: See Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

b. Pt has an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate OR C. Pt's sex is a female with a diagnosis of breast cancer who is receiving aromatase inhibitor therapy AND ONE of: i. Pt's medication history includes use of a bisphosphonate OR ii. Pt has an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate OR D. Pt's sex is male with a diagnosis of prostate cancer receiving androgen deprivation therapy (ADT) AND ONE of: i. Pt's medication history includes use of a bisphosphonate OR ii. Pt has an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate OR E. Pt has a diagnosis of glucocorticoid-induced osteoporosis AND ALL of: i. Pt is either initiating or continuing systemic glucocorticoids in a daily dose equivalent to 7.5 mg or greater of prednisone AND ii. Pt is expected to remain on glucocorticoids for at least 6 months AND iii. Pt's diagnosis was confirmed by ONE of: 1. A fragility fracture in the hip or spine OR 2. A T-score of -2.5 or lower OR 3. A T-score of -1.0 to -2.5 AND ONE of: a. A fragility fracture of the proximal humerus, pelvis, or distal forearm OR b. A FRAX 10-year probability for major osteoporotic fracture of 20% or greater OR c. A FRAX 10-year probability of hip fracture of 3% or greater AND iv. ONE of: 1. Pt is at high fracture risk as defined by ONE of: a. Pt had a recent fracture (within the past 12 months) OR b. Pt had fractures while on FDA approved osteoporosis therapy OR c. Pt has had multiple fractures OR d. Pt had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR e. Pt has a very low T-score (less than -2.5) OR f. Pt is at high risk for falls or has a history of injurious falls OR g. Pt has a high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 20%, hip fracture greater than 3%) or by other validated fracture risk algorithm OR 2. ONE of: a. Pt's medication history includes use of a bisphosphonate OR b. Pt has an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate AND 2. ONE of: A. Pt has a pretreatment or current calcium level that is NOT below the lower limit of the testing laboratory's normal range OR B. Pt has a pretreatment or current calcium level that is below the lower limit of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR C. Prescriber has indicated that the pt is not at risk for hypocalcemia (not including risk associated with the requested agent) AND 3. Pt will NOT be using the requested agent in combination with a bisphosphonate, another form of denosumab, romosozumab-aqqg, or parathyroid hormone analog (e.g., abaloparatide, teriparatide) for the requested indication AND 4. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

PROMACTA PA

MEDICATION(S)
ELTROMBOPAG OLAMINE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. ONE of the following: A. Patient (pt) has a diagnosis of persistent or chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following: i. Pt has tried and had an insufficient response to a corticosteroid or immunoglobulin (IVIg or anti-D) OR ii. Pt has an intolerance or hypersensitivity to a corticosteroid or immunoglobulin (IVIg or anti-D) OR iii. Pt has an FDA labeled contraindication to a corticosteroid or immunoglobulin (IVIg or anti-D) OR iv. Pt has had an insufficient response to a splenectomy OR B. Pt has a diagnosis of hepatitis C associated thrombocytopenia AND ONE of the following: i. Pt's platelet count is less than 75 x 10^9/L AND the intent is to increase platelet counts sufficiently to initiate interferon therapy OR ii. Pt is on concomitant therapy with interferon therapy AND is at risk for discontinuing hepatitis C therapy due to thrombocytopenia OR C. Pt has a diagnosis of severe aplastic anemia (SAA) AND ALL of the following: i. Pt has at least 2 of the following blood criteria: 1. Neutrophils less than 0.5 X 10^9/L OR 2. Platelets less than 30 X 10^9/L OR 3. Reticulocyte count less than 60 X 10^9/L AND ii. Pt has at least 1 of the following marrow criteria: 1. Severe hypocellularity is less than 25% OR 2. Moderate hypocellularity is 25-50% with hematopoietic cells representing less than 30% of residual cells AND iii. ONE of the following: 1. Pt has tried and had an insufficient response to BOTH antithymocyte globulin (ATG) AND cyclosporine therapy OR 2. BOTH of the following: a. Pt will be using the requested agent as first-line treatment (i.e., has not been treated with ATG and/or cyclosporine) AND b. Pt will use the requested agent in combination with standard immunosuppressive therapy (i.e., ATG AND cyclosporine) OR Initial criteria continues: see Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 6 months for ITP. Renewal: 12 months for ITP. Other indications, see Other Criteria.

OTHER CRITERIA
D. Pt has another indication that is supported in CMS approved compendia for the requested agent AND 2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Pt has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Pt has a diagnosis of persistent or chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following: i. Pt's platelet count is 50 x 10^9/L or greater OR ii. Pt's platelet count has increased sufficiently to avoid clinically significant bleeding OR B. Pt has a diagnosis of hepatitis C associated thrombocytopenia AND BOTH of the following: i. ONE of the following: 1. Pt will be initiating hepatitis C therapy with interferon therapy OR 2. Pt will be maintaining hepatitis C therapy with interferon therapy at the same time as the requested agent AND ii. ONE of the following: 1. Pt's platelet count is 90 x 10^9/L or greater OR 2. Pt's platelet count has increased sufficiently to initiate or maintain interferon therapy for the treatment of hepatitis C OR C. Pt has a diagnosis of severe aplastic anemia (SAA) AND the pt has had clinical benefit with the requested agent OR D. Pt has another indication that is supported in CMS approved compendia and the pt has had clinical benefit with the requested agent AND 3. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication Initial: 48 weeks for hepatitis C associated thrombocytopenia, 6 months for first-line therapy in severe aplastic anemia, 16 weeks for SAA, 12 months for All other indications Renewal: 48 weeks for hepatitis C associated thrombocytopenia, 12 months for SAA, 12 months for All other indications

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PULMONARY HYPERTENSION PA - ADEMPAS

MEDICATION(S)
ADEMPAS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND ii. Patient has an FDA labeled indication for the requested agent OR B. Patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH), WHO Group 4, as determined by a ventilation-perfusion scan and a confirmatory selective pulmonary angiography AND ALL of the following: i. ONE of the following: a. Patient is NOT a candidate for surgery OR b. Patient has had pulmonary endarterectomy AND has persistent or recurrent disease AND ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND iv. Patient has a pulmonary vascular resistance greater than or equal to 2 Wood units OR C. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following: i. Patient's World Health Organization (WHO) functional class is II or greater AND ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND iv. Patient has a pulmonary vascular resistance greater than or equal to 2 Wood units AND Initial criteria continues: see Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
v. ONE of the following: a. The requested agent will be utilized as monotherapy OR b. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), AND BOTH of the following: 1. Patient has unacceptable or deteriorating clinical status despite established pharmacotherapy AND 2. The requested agent is in a different therapeutic class OR c. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND BOTH of the following: 1. Patient has unacceptable or deteriorating clinical status despite established pharmacotherapy AND 2. All three agents in the triple therapy are from a different therapeutic class Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PULMONARY HYPERTENSION PA - AMBRISENTAN

MEDICATION(S)
AMBRISENTAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND ii. Patient has an FDA labeled indication for the requested agent OR B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following: i. Patient's World Health Organization (WHO) functional class is II or greater AND ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND iv. Patient has a pulmonary vascular resistance greater than or equal to 2 Wood units AND v. ONE of the following: a. The requested agent will be utilized as monotherapy OR b. The requested agent will be used in combination with a phosphodiesterase 5 (PDE5) inhibitor for dual therapy ONLY OR c. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), [except for dual therapy requests for a phosphodiesterase 5 (PDE 5) inhibitor plus an endothelin receptor antagonist (ERA)], AND BOTH of the following: 1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND 2. The requested agent is in a different therapeutic class OR Initial criteria continues: see Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND BOTH of the following: 1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND 2. All three agents in the triple therapy are from a different therapeutic class OR e. The requested agent will be utilized as part of triple therapy in a treatment naive patient AND BOTH of the following: 1. Patient is classified as WHO functional class IV or has been assessed as high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND 2. The three agents being utilized consist of: ERA plus PDE5i plus prostanoid Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PULMONARY HYPERTENSION PA - BOSENTAN

MEDICATION(S)
BOSENTAN 125 MG TABLET, BOSENTAN 62.5 MG TABLET, TRACLEER 32 MG TABLET FOR SUSP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Elevated liver enzymes accompanied by signs or symptoms of liver dysfunction/injury or a bilirubin level of 2 times the ULN (upper limit of normal) or greater AND FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1, as determined by right heart catheterization, AND ALL of the following: i. Patient's World Health Organization (WHO) functional class is II or greater AND ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND iv. Patient has a pulmonary vascular resistance greater than or equal to 2 Wood units AND v. ONE of the following: a. The requested agent will be utilized as monotherapy OR b. The requested agent will be used in combination with a phosphodiesterase 5 (PDE5) inhibitor for dual therapy ONLY OR c. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), [except for dual therapy requests for a phosphodiesterase 5 inhibitor (PDE5) plus an endothelin receptor antagonist (ERA)], AND BOTH of the following: 1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND 2. The requested agent is in a different therapeutic class OR Initial criteria continues: see Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND BOTH of the following: 1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND 2. All three agents in the triple therapy are from a different therapeutic class OR e. The requested agent will be utilized as part of triple therapy in a treatment naive patient AND BOTH of the following: 1. Patient is classified as WHO functional class IV or has been assessed as high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND 2. The three agents being utilized consist of: ERA plus PDE5i plus prostanoid OR C. Patient has an indication that is supported in CMS approved compendia for the requested agent Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 3. Patient has had clinical benefit with the requested agent

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PULMONARY HYPERTENSION PA - ORENITRAM

MEDICATION(S)
ORENITRAM ER, ORENITRAM MONTH 1 TITRATION KT, ORENITRAM MONTH 2 TITRATION KT, ORENITRAM MONTH 3 TITRATION KT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND ii. Patient has an FDA labeled indication for the requested agent OR B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following: i. Patient's World Health Organization (WHO) functional class is II or greater AND ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND iv. Patient has a pulmonary vascular resistance greater than or equal to 2 Wood units AND v. ONE of the following: a. The requested agent will be utilized as monotherapy OR b. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), AND BOTH of the following: 1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND 2. The requested agent is in a different therapeutic class OR c. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND ALL of the following: 1. Patient is WHO functional class III or IV or has been assessed as intermediate to high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND 2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND 3. All three agents in the triple therapy are from a different therapeutic class OR Initial criteria continues: see Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
d. The requested agent will be utilized as part of triple therapy in a treatment naive patient AND BOTH of the following: 1. Patient is classified as WHO functional class IV or has been assessed as high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND 2. The three agents being utilized consist of: ERA plus PDE5i plus prostanoid OR e. The requested agent will be utilized for add-on therapy to existing triple therapy (quadruple therapy), AND ALL of the following: 1. Patient is WHO functional class III or IV or has been assessed as intermediate to high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND 2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND 3. All four agents in the quadruple therapy are from a different therapeutic class Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PULMONARY HYPERTENSION PA - SILDENAFIL

MEDICATION(S)
SILDENAFIL 20 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concurrently taking another phosphodiesterase 5 (PDE5) inhibitor with the requested agent AND FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following: i. Patient's World Health Organization (WHO) functional class is II or greater AND ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND iv. Patient has a pulmonary vascular resistance greater than or equal to 2 Wood units AND v. ONE of the following: a. The requested agent will be utilized as monotherapy OR b. The requested agent will be used in combination with an endothelin receptor antagonist (ERA) for dual therapy ONLY OR c. The requested agent will be utilized for add-on therapy to existing monotherapy, [except for dual requests for a phosphodiesterase 5 (PDE5) inhibitor plus an endothelin receptor antagonist (ERA)], AND BOTH of the following: 1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND 2. The requested agent is in a different therapeutic class OR Initial criteria continues: see Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy) AND BOTH of the following: 1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND 2. All three agents in the triple therapy are from a different therapeutic class OR e. The requested agent will be utilized as part of triple therapy in a treatment naive patient AND BOTH of the following: 1. Patient is classified as WHO functional class IV or has been assessed as high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND 2. The three agents being utilized consist of: ERA plus PDE5i plus prostanoid OR C. Patient has an indication that is supported in CMS approved compendia for the requested agent Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 3. Patient has had clinical benefit with the requested agent

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

PULMONARY HYPERTENSION PA - TADALAFIL

MEDICATION(S)
TADALAFIL 20MG TABLET (GENERIC ADCIRCA)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concurrently taking another phosphodiesterase 5 (PDE5) inhibitor with the requested agent AND FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following: i. Patient's World Health Organization (WHO) functional class is II or greater AND ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND iv. Patient has a pulmonary vascular resistance greater than or equal to 2 Wood units AND v. ONE of the following: a. The requested agent will be utilized as monotherapy OR b. The requested agent will be used in combination with an endothelin receptor antagonist (ERA) for dual therapy ONLY OR c. The requested agent will be utilized for add-on therapy to existing monotherapy, [except for dual requests for a phosphodiesterase 5 (PDE5) inhibitor plus an endothelin receptor antagonist (ERA)], AND BOTH of the following: 1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND 2. The requested agent is in a different therapeutic class OR Initial criteria continues: see Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy) AND BOTH of the following: 1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND 2. All three agents in the triple therapy are from a different therapeutic class OR e. The requested agent will be utilized as part of triple therapy in a treatment naive patient AND BOTH of the following: 1. Patient is classified as WHO functional class IV or has been assessed as high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND 2. The three agents being utilized consist of: ERA plus PDE5i plus prostanoid OR C. Patient has an indication that is supported in CMS approved compendia for the requested agent Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 3. Patient has had clinical benefit with the requested agent

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

PULMONARY HYPERTENSION PA - VENTAVIS

MEDICATION(S)
VENTAVIS

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PULMONARY HYPERTENSION PA - WINREVAIR

MEDICATION(S)
WINREVAIR, WINREVAIR (2 PACK)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND ii. Patient has an FDA labeled indication for the requested agent OR B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following: i. Patient's World Health Organization (WHO) functional class is II or greater AND ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND iv. Patient has a pulmonary vascular resistance greater than or equal to 2 Wood units AND v. ALL of the following: a. The requested agent will be utilized for add-on therapy AND b. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND c. All agents in the therapy are from a different therapeutic class Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

PYRIMETHAMINE PA

MEDICATION(S)
PYRIMETHAMINE 25 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 6 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PYRUKYND PA

MEDICATION(S)
PYRUKYND

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. Patient has a diagnosis of hemolytic anemia with pyruvate kinase deficiency (PKD) AND ALL of the following: A. ONE of the following: i. Genetic testing showing a pathogenic PKLR gene mutation OR ii. Patient does NOT have two known pathogenic mutations in the PKLR gene, AND patient has a decrease in pyruvate kinase enzyme activity AND B. Patient is NOT homozygous for the c.1436G to A (p.R479H) variant AND C. Patient has at least 2 variant alleles in the PKLR gene, of which at least 1 is a missense variant AND D. Patient does NOT have two non-missense mutations Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of hemolytic anemia with pyruvate kinase deficiency (PKD) AND 3. Patient has had clinical benefit with the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., hematologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

QUININE PA

MEDICATION(S)
QUININE SULFATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has ONE of the following diagnoses: A. Uncomplicated malaria OR B. Babesiosis OR C. An indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be 7 days for malaria, 10 days for babesiosis, 12 months for all other diagnoses

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

REGRANEX PA

MEDICATION(S)
REGRANEX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. Patient has a diagnosis of lower extremity diabetic neuropathic ulcer(s) that extends into the subcutaneous tissue or beyond AND ii. The ulcer(s) intended for treatment has an adequate blood supply OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

REPATHA PA

MEDICATION(S)
REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has ONE of the following: A. A diagnosis of heterozygous familial hypercholesterolemia (HeFH) AND ONE of the following: i. Genetic confirmation of one mutant allele at the LDLR, Apo-B, PCSK9, or 1/LDLRAP1 gene OR ii. ONE of the following: a. Patient is 18 years of age or older AND has a pretreatment LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) OR b. Patient is between the ages of 10 and less than 18 years of age AND has a pretreatment LDL-C greater than 155 mg/dL (greater than 4.0 mmol/L) OR iii. Clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, corneal arcus, tuberous xanthoma, or xanthelasma) OR iv. "Definite" or "possible" familial hypercholesterolemia as defined by the Simon Broome criteria OR v. A Dutch Lipid Clinic Network criteria score of greater than 5 OR vi. A treated low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 100 mg/dL after treatment with antihyperlipidemic agents but prior to PCSK9 inhibitor therapy OR B. A diagnosis of homozygous familial hypercholesterolemia (HoFH) AND ONE of the following: i. Genetic confirmation of bi-allelic pathogenic/likely pathogenic variants on different chromosomes at the LDLR, Apo-B, PCSK9, or LDLRAP1 genes or greater than or equal to 2 such variants at different loci OR ii. History of untreated LDL-C greater than 400 mg/dL (greater than 10 mmol/L) AND ONE of the following: a. Cutaneous or tendon xanthomas before 10 years of age OR b. Untreated elevated LDL-C levels consistent with heterozygous familial hypercholesterolemia (HeFH) in both parents (or in digenic form, one parent may have normal LDL-C levels and the other may have LDL-C levels consistent with HoFH) OR Initial criteria continues: see Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
C. BOTH of the following: i. A diagnosis of established cardiovascular disease [acute coronary syndrome (ACS), history of myocardial infarction (MI), stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack (TIA), peripheral artery disease (PAD) including aortic aneurysm] AND ii. The requested agent will be used to reduce the risk of major adverse cardiovascular (CV) events (CV death, myocardial infarction, stroke, unstable angina requiring hospitalization, or coronary revascularization) OR D. A diagnosis of primary hyperlipidemia (not associated with HeFH, HoFH, or established cardiovascular disease) OR E. Patient has another indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. Patient has tried and had an inadequate response to a high-intensity statin (i.e., rosuvastatin 20-40 mg or atorvastatin 40-80 mg) OR B. Patient has an intolerance to TWO different statins OR C. Patient has an FDA labeled contraindication to a statin AND 3. Patient will NOT be using the requested agent in combination with another PCSK9 agent Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another PCSK9 agent

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

REVCOVI PA

MEDICATION(S)
REVCOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has a diagnosis of adenosine deaminase severe combined immune deficiency (ADA-SCID) confirmed by ONE of the following: A. Molecular genetic confirmation of mutations in both alleles of the ADA1 gene OR B. Deficiency or absence of ADA in lysed erythrocytes, fibroblasts (cultured from amniotic fluid), or chorionic villus OR C. Positive screening by T cell receptor excision circles (TRECs) OR D. Increase in deoxyadenosine triphosphate (dATP) levels in erythrocyte lysates over the testing laboratory's upper limit of the normal range AND 2. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of adenosine deaminase severe combined immune deficiency (ADA-SCID) AND 3. Patient has had clinical benefit with the requested agent AND 4. The requested dose is within FDA labeled dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist, hematologist, immunologist, oncologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

REZDIFFRA PA

MEDICATION(S)
REZDIFFRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Decompensated cirrhosis AND Moderate to severe hepatic impairment (Child-Pugh Class B or C)

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has a diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis AND 2. Patient has stage F2 or F3 fibrosis as confirmed by BOTH of the following (prior to therapy with the requested agent): A. A FIB-4 score consistent with stage F2 or F3 fibrosis adjusted for age AND B. ONE of the following: i. A liver biopsy OR ii. ONE of the following: 1. Vibration-controlled transient elastography (VCTE, e.g., Fibroscan) OR 2. Enhanced liver fibrosis (ELF) OR 3. Magnetic resonance elastography (MRE) Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis AND 3. Patient has had clinical benefit with the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., hepatologist, gastroenterologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

RITALIN PA

MEDICATION(S)
METHYLPHENIDATE 10 MG TABLET, METHYLPHENIDATE 20 MG TABLET, METHYLPHENIDATE 5 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ROFLUMILAST PA

MEDICATION(S)
ROFLUMILAST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. Patient is currently being treated with a long-acting beta-2 agonist (LABA) and long-acting muscarinic antagonist (LAMA) combination with or without an inhaled corticosteroid (ICS) OR B. Patient has an intolerance or hypersensitivity to a long-acting beta-2 agonist (LABA) and long-acting muscarinic antagonist (LAMA) combination OR C. Patient has an FDA labeled contraindication to a long-acting beta-2 agonist (LABA) and long-acting muscarinic antagonist (LAMA) combination

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

RYBELSUS PA

MEDICATION(S)
RYBELSUS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Requested agent will be used for weight loss alone

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR C. ALL of the following: i. Patient does NOT have any FDA labeled contraindications to the requested agent AND ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

SAPROPTERIN PA

MEDICATION(S)
SAPROPTERIN DIHYDROCHLORIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of phenylketonuria (PKU) AND 2. Prescriber has submitted a baseline blood Phe level measured prior to initiation of therapy with the requested agent, which is above the recommended levels indicated for the patient's age range or condition AND 3. Patient will NOT be using the requested agent in combination with Palynziq (pegvaliase-pqpz) for the requested indication AND 4. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of phenylketonuria (PKU) AND 3. ONE of the following: a. Patient's blood Phe levels are being maintained within the acceptable range OR b. Patient has had a decrease in blood Phe level from baseline AND 4. Patient will NOT be using the requested agent in combination with Palynziq (pegvaliase-pqpz) for the requested indication AND 5. The requested dose is within FDA labeled dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., metabolic or genetic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Initial: 2 months if dose is 5 to less than 20 mg/kg/day, 1 month if 20 mg/kg/day Renewal: 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

SELF - ADMINISTERED ONCOLOGY PA

MEDICATION(S)

ABIRATERONE ACETATE 250 MG TAB, ABIRTEGA, AKEEGA, ALECENSA, ALUNBRIG, AUGTYRO, AVMAPKI-FAKZYNJA, AYVAKIT, BALVERSA, BESREMI, BEXAROTENE 75 MG CAPSULE, BOSULIF, BRAFTOVI 75 MG CAPSULE, BRUKINSA, CABOMETYX, CALQUENCE 100 MG TABLET, CAPRELSA, COMETRIQ, COPIKTRA, COTELLIC, DANZITEN, DASATINIB, DAURISMO, ERIVEDGE, ERLEADA, ERLOTINIB HCL 100 MG TABLET, ERLOTINIB HCL 150 MG TABLET, ERLOTINIB HCL 25 MG TABLET, EVEROLIMUS 10 MG TABLET, EVEROLIMUS 2 MG TAB FOR SUSP, EVEROLIMUS 2.5 MG TABLET, EVEROLIMUS 3 MG TAB FOR SUSP, EVEROLIMUS 5 MG TAB FOR SUSP, EVEROLIMUS 5 MG TABLET, EVEROLIMUS 7.5 MG TABLET, FOTIVDA, FRUZAQLA, GAVRETO, GEFITINIB, GILOTRIF, GOMEKLI, IBRANCE, IBTROZI, ICLUSIG, IDHIFA, IMATINIB MESYLATE 100 MG TAB, IMATINIB MESYLATE 400 MG TAB, IMBRUVICA 140 MG CAPSULE, IMBRUVICA 140 MG TABLET, IMBRUVICA 280 MG TABLET, IMBRUVICA 420 MG TABLET, IMBRUVICA 70 MG CAPSULE, IMBRUVICA 70 MG/ML SUSPENSION, IMKELDI, INLYTA, INQOVI, INREBIC, ITOVEBI, IWILFIN, JAKAFI, JAYPIRCA, KISQALI, KISQALI FEMARA CO-PACK, KOSELUGO, KRAZATI, LAPATINIB, LAZCLUZE, LENALIDOMIDE, LENVIMA, LONSURF, LORBRENA, LUMAKRAS, LYNPARZA, LYTGOBI, MATULANE, MEKINIST, MEKTOVI, NERLYNX, NILOTINIB HCL, NINLARO, NUBEQA, ODOMZO, OGSIVEO, OJEMDA, OJJAARA, ONUREG, ORGOVYX, ORSERDU, PAZOPANIB HCL, PEMAZYRE, PIQRAY, POMALYST, QINLOCK, RETEVMO, REVUFORJ, REZLIDHIA, ROMVIMZA, ROZLYTREK, RUBRACA, RYDAPT, SCEMBLIX, SORAFENIB, STIVARGA, SUNITINIB MALATE, TABRECTA, TAFINLAR, TAGRISSO, TALZENNA, TAZVERIK, TEPMETKO, THALOMID, TIBSOVO, TORPENZ, TRETINOIN 10 MG CAPSULE, TRUQAP, TUKYSA, TURALIO 125 MG CAPSULE, VANFLYTA, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, VONJO, VORANIGO, WELIREG, XALKORI, XOSPATA, XPOVIO, XPOVIO 40 MG ONCE WEEKLY, XTANDI, ZEJULA 100 MG TABLET, ZEJULA 200 MG TABLET, ZEJULA 300 MG TABLET, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA 150 MG TABLET

PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. ALL of the following: i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND iii. ONE of the following: a. The requested agent is FDA labeled or supported by CMS approved compendia as a first-line therapy for the requested indication OR b. Patient has tried appropriate FDA labeled or CMS approved compendia supported therapy that are indicated as first-line therapy for the requested indication OR c. Patient has an intolerance or hypersensitivity to the first-line therapy for the requested indication OR d. Patient has an FDA labeled contraindication to the first-line therapy for the requested indication AND iv. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines AND Criteria continues: see Other Criteria

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

v. ONE of the following: a. The requested agent is not Bosulif OR b. The requested agent is Bosulif AND ONE of the following: 1. Patient's medication history indicates use of imatinib OR dasatinib for the requested indication (if applicable) OR 2. Patient has an intolerance or hypersensitivity to imatinib OR dasatinib OR 3. Patient has an FDA labeled contraindication to imatinib OR dasatinib OR 4. CMS approved compendia does not support the use of imatinib OR dasatinib for the requested indication OR 5. Prescriber has provided information in support of use of Bosulif over imatinib OR dasatinib for the requested indication AND vi. ONE of the following: a. The requested agent is not Ibrance OR b. The requested agent is Ibrance AND ONE of the following: 1. Patient's medication history indicates use of Kisqali, Kisqali/Femara, OR Verzenio for the requested indication (if applicable) OR 2. Patient has an intolerance or hypersensitivity to Kisqali, Kisqali/Femara, OR Verzenio OR 3. Patient has an FDA labeled contraindication to Kisqali, Kisqali/Femara, OR Verzenio OR 4. CMS approved compendia does not support the use of Kisqali, Kisqali/Femara, OR Verzenio for the requested indication OR 5.

Prescriber has provided information in support of use of Ibrance over Kisqali, Kisqali/Femara, OR Verzenio for the requested indication AND vii. ONE of the following: a. The requested agent is not Ojjaara OR Inrebic OR b. The requested agent is Ojjaara OR Inrebic AND ONE of the following: 1. Patient's medication history indicates use of Jakafi for the requested indication (if applicable) OR 2. Patient has an intolerance or hypersensitivity to Jakafi OR 3. Patient has an FDA labeled contraindication to Jakafi OR 4. CMS approved compendia does not support the use of Jakafi for the requested indication OR 5. Prescriber has provided information in support of use of Ojjaara OR Inrebic over Jakafi for the requested indication

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

SIGNIFOR LAR PA

MEDICATION(S)
SIGNIFOR LAR

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SIGNIFOR PA

MEDICATION(S)
SIGNIFOR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Severe hepatic impairment (i.e., Child Pugh C)

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of Cushing's disease (CD) AND ONE of the following: i. Patient had an inadequate response to pituitary surgical resection OR ii. Patient is NOT a candidate for pituitary surgical resection OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent Criteria for renewal approval require BOTH of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of Cushing's disease (CD) AND BOTH of the following: i. Patient has a urinary free cortisol level less than or equal to the upper limit of normal AND ii. Patient has had improvement in at least ONE of the following clinical signs and symptoms: 1. Fasting plasma glucose OR 2. Hemoglobin A1c OR 3. Hypertension OR 4. Weight OR B. BOTH of the following: i. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient has had clinical benefit with the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial approval: 6 months for CD, 12 months for all other diagnoses, Renewal approval: 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

SIVEXTRO PA

MEDICATION(S)
SIVEXTRO 200 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. Patient has ONE of the following: A. BOTH of the following: i. A documented acute bacterial skin and skin structure infection (ABSSSI) defined as a bacterial infection of the skin with a lesion size area of at least 75 cm2 (lesion size measured by the area of redness, edema, or induration) AND ii. The infection is due to Staphylococcus aureus, Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus anginosus, Streptococcus intermedius, Streptococcus constellatus, or Enterococcus faecalis OR B. Another indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. The requested agent is prescribed by an infectious disease specialist or the prescriber has consulted with an infectious disease specialist on treatment of this patient OR B. The requested agent is NOT prescribed by an infectious disease specialist or the prescriber has NOT consulted with an infectious disease specialist on treatment of this patient AND ONE of the following: i. There is documentation of resistance to TWO of the following: beta-lactams, macrolides, clindamycin, tetracycline, or co-trimoxazole at the site of infection OR ii. Patient has an intolerance or hypersensitivity to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR iii. Patient has an FDA labeled contraindication to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR iv. There is documentation of resistance to vancomycin at the site of infection OR v. Patient has an intolerance or hypersensitivity to vancomycin OR vi. Patient has an FDA labeled contraindication to vancomycin AND 3. Patient will NOT be using the requested agent in combination with linezolid for the same infection AND 4. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

AGE RESTRICTION
Patient is within the FDA labeled age for the requested agent

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approval will be 6 days for ABSSSI or 30 days for all other indications

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

SODIUM OXYBATE PA

MEDICATION(S)
SODIUM OXYBATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of narcolepsy with cataplexy OR B. BOTH of the following: i. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness AND ii. ONE of the following: a. Patient is between the ages of 7 and less than 18 years OR b. BOTH of the following: 1. Patient is 18 years of age or over AND 2. ONE of the following: a) Patient has tried and had an inadequate response to modafinil or armodafinil OR b) Patient has an intolerance or hypersensitivity to modafinil or armodafinil OR c) Patient has an FDA labeled contraindication to modafinil or armodafinil OR C. Patient has another indication that is supported in CMS approved compendia for the requested agent Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of narcolepsy with cataplexy OR B. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness OR C. Patient has another indication that is supported in CMS approved compendia for the requested agent AND 3. Patient has had clinical benefit with the requested agent

AGE RESTRICTION
For diagnosis of narcolepsy with cataplexy, patient is 7 years of age or over. For diagnosis of narcolepsy with excessive daytime sleepiness, patient is 7 years of age or over.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

SOMATOSTATIN ANALOGS PA - LANREOTIDE

MEDICATION(S)
SOMATULINE DEPOT

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SOMATOSTATIN ANALOGS PA - OCTREOTIDE

MEDICATION(S)
OCTREOTIDE ACETATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. ONE of the following: A. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following: i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR ii. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR B. ONE of the following: i. Patient has a diagnosis of acromegaly AND ONE of the following: a. Patient is not a candidate for surgical resection or pituitary radiation therapy OR b. The requested agent is for adjunctive therapy with pituitary radiation therapy OR c. Patient had an inadequate response to surgery or pituitary radiation therapy as indicated by growth hormone levels or serum IGF-1 levels that are above the reference range OR ii. Patient has severe diarrhea and/or flushing episodes associated with metastatic carcinoid tumors OR iii. Patient has profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors OR iv. Patient has a diagnosis of dumping syndrome AND ONE of the following: a. Patient has tried and had an inadequate response to acarbose OR b. Patient has an intolerance or hypersensitivity to acarbose OR c. Patient has an FDA labeled contraindication to acarbose OR v. Patient has another indication that is supported in CMS approved compendia for the requested agent AND 2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION
Approval will be 6 months for initial, 12 months for renewal

OTHER CRITERIA
Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of acromegaly OR B. Patient has severe diarrhea and/or flushing episodes associated with metastatic carcinoid tumors OR C. Patient has profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors OR D. Patient has a diagnosis of dumping syndrome OR E. Patient has another indication that is supported in CMS approved compendia for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SOMATOSTATIN ANALOGS PA - SOMAVERT

MEDICATION(S)
SOMAVERT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has a diagnosis of acromegaly AND ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. BOTH of the following: i. ONE of the following: a. Patient is not a candidate for surgical resection or pituitary radiation therapy OR b. The requested agent is for adjunctive therapy with pituitary radiation therapy OR c. Patient had an inadequate response to surgery or pituitary radiation therapy as indicated by serum IGF-1 levels that are above the reference range AND ii. ONE of the following: a. Patient has tried and had an inadequate response to octreotide or lanreotide OR b. Patient has an intolerance or hypersensitivity to octreotide or lanreotide OR c. Patient has an FDA labeled contraindication to octreotide or lanreotide AND 2. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of acromegaly AND 3. Patient has had clinical benefit with the requested agent AND 4. The requested dose is within FDA labeled dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Approval will be 6 months for initial, 12 months for renewal

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

STRENSIQ PA

MEDICATION(S)
STRENSIQ

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SUBSTRATE REDUCTION THERAPY PA - MIGLUSTAT

MEDICATION(S)
MIGLUSTAT, YARGESA

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Niemann-Pick disease type C (NPC)

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. Patient has a diagnosis of Gaucher disease type 1 (GD1) confirmed by ONE of the following: a. A baseline (prior to therapy for the requested indication) glucocerebrosidase enzyme activity of less than or equal to 15% of mean normal in peripheral blood leukocytes, fibroblasts, or other nucleated cells OR b. Confirmation of genetic mutation of the glucocerebrosidase (GBA) gene with two disease-causing alleles AND ii. Prior to any treatment for the intended diagnosis, the patient has had at least ONE of the following clinical presentations: a. Anemia [defined as mean hemoglobin (Hb) level below the testing laboratory's lower limit of the normal range based on age and gender] OR b. Thrombocytopenia (defined as platelet count of less than 100,000 per microliter) OR c. Hepatomegaly OR d. Splenomegaly OR e. Growth failure (i.e., growth velocity is below the standard mean for age) OR f. Evidence of bone disease with other causes ruled out OR B. ALL of the following: i. Patient has a diagnosis of Niemann-Pick disease type C (NPC) as confirmed by genetic analysis mutation in the NPC1 or NPC2 genes AND ii. The requested agent will be used for the treatment of neurological manifestations of Niemann-Pick disease type C (NPC) AND iii. The requested agent will be used in combination with Miplyffa (arimoclomol)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, gastroenterologist, geneticist, hematologist, hepatologist, neurologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following A. Patient has a diagnosis of Gaucher disease type 1 (GD1) OR B. ALL of the following: i. Patient has a diagnosis of Niemann-Pick disease type C (NPC) AND ii. The requested agent will be used for the treatment of neurological manifestations of Niemann-Pick disease type C (NPC) AND iii. The requested agent will be used in combination with Miplyffa (arimoclomol) AND 3. Patient has had clinical benefit with the requested agent

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TASIMELTEON CAPSULE PA

MEDICATION(S)
TASIMELTEON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. Patient has a diagnosis of Non-24-hour sleep-wake disorder AND ii. Patient is totally blind (i.e., no light perception) OR B. BOTH of the following: i. Patient has a diagnosis of Smith-Magenis Syndrome (SMS) confirmed by the presence of ONE of the following genetic mutations: A. A heterozygous deletion of 17p11.2 OR B. A heterozygous pathogenic variant involving RAI1 AND ii. The requested agent is being used to treat nighttime sleep disturbances associated with SMS

AGE RESTRICTION
For diagnosis of Non-24-hour sleep-wake disorder, patient is 18 years of age or over. For diagnosis of Smith-Magenis Syndrome (SMS), patient is 16 years of age or over.

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist, sleep specialist, psychiatrist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

TERIPARATIDE PA

MEDICATION(S)
BONSITY, TERIPARATIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. Patient has ONE of the following: A. Postmenopausal osteoporosis OR B. Patient's sex is male with primary or hypogonadal osteoporosis OR C. Osteoporosis with sustained systemic glucocorticoid therapy AND 2. Patient's diagnosis was confirmed by ONE of the following: A. A fragility fracture in the hip or spine OR B. A T-score of -2.5 or lower OR C. A T-score of -1.0 to -2.5 AND ONE of the following: i. A fragility fracture of the proximal humerus, pelvis, or distal forearm OR ii. A FRAX 10-year probability for major osteoporotic fracture of 20% or greater OR iii. A FRAX 10-year probability of hip fracture of 3% or greater AND 3. ONE of the following: A. Patient is at high fracture risk as defined by ONE of the following: i. Patient had a recent fracture (within the past 12 months) OR ii. Patient had fractures while on FDA approved osteoporosis therapy OR iii. Patient has had multiple fractures OR iv. Patient had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR v. Patient has a very low T-score (less than -2.5) OR vi. Patient is at high risk for falls or has a history of injurious falls OR vii. Patient has a high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 20%, hip fracture greater than 3%) or by other validated fracture risk algorithm OR B. ONE of the following: i. Patient has tried and had an inadequate response to a bisphosphonate OR ii. Patient has an intolerance or hypersensitivity to a bisphosphonate OR iii. Patient has an FDA labeled contraindication to a bisphosphonate AND 4. Patient will NOT be using the requested agent in combination with a bisphosphonate, denosumab (e.g., Prolia, Xgeva), romosozumab-aqqg, or another parathyroid hormone analog (e.g., abaloparatide) for the requested indication AND Criteria continues: see Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
No prior teriparatide and/or Tymlos use approve 2 years, Prior use - see Other Criteria

OTHER CRITERIA
5. The requested dose is within FDA labeled dosing for the requested indication AND 6. ONE of the following: A. Patient has never received treatment with teriparatide or Tymlos (abaloparatide) OR B. Patient has been previously treated with teriparatide or Tymlos (abaloparatide) AND ONE of the following: i. The total cumulative duration of treatment with teriparatide and Tymlos (abaloparatide) has NOT exceeded 2 years OR ii. Patient has received 2 years or more of treatment with teriparatide, or a combination of teriparatide and Tymlos (abaloparatide), and remains at or has returned to having a high risk for fracture Prior teriparatide and/or Tymlos use approve remainder of 2 years of total cumulative therapy. Approve 1 year if patient has received 2 years or more teriparatide or a combination of teriparatide and Tymlos (abaloparatide)

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TETRABENAZINE PA

MEDICATION(S)
TETRABENAZINE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. ONE of the following: A. Patient has a diagnosis of chorea associated with Huntington's disease OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. Patient does NOT have a current diagnosis of depression OR B. Patient has a current diagnosis of depression and is being treated for depression AND 3. ONE of the following: A. Patient does NOT have a diagnosis of suicidal ideation and/or behavior OR B. Patient has a diagnosis of suicidal ideation and/or behavior and must NOT be actively suicidal AND 4. Patient will NOT be using the requested agent in combination with a monoamine oxidase inhibitor (MAOI) AND 5. Patient will NOT be using the requested agent in combination with reserpine

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

TOBRAMYCIN NEB PA

MEDICATION(S)
TOBRAMYCIN 300 MG/5 ML AMPULE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. Patient has a diagnosis of cystic fibrosis AND 2. Documentation has been provided that indicates the patient has a Pseudomonas aeruginosa respiratory infection AND 3. ONE of the following: a. Patient is NOT currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam) OR b. Patient is currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam) AND ONE of the following: i. Prescriber has confirmed that the other inhaled antibiotic will be discontinued, and that therapy will be continued only with the requested agent OR ii. Prescriber has provided information in support of another inhaled antibiotic therapy used concurrently with or alternating with (i.e., continuous alternating therapy) the requested agent Drug is also subject to Part B versus Part D review.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

TOPICAL DICLOFENAC 3% GEL PA

MEDICATION(S)
DICLOFENAC SODIUM 3% GEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has a diagnosis of actinic keratosis (AK)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 3 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOPICAL NSAID PA - PENNSAID

MEDICATION(S)
DICLOFENAC 1.5% TOPICAL SOLN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of the following: a. Patient has an FDA labeled indication for the requested agent OR b. Patient has an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be 3 months for acute pain, 12 months for all other diagnoses

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOPICAL RETINOIDS PA - TAZAROTENE

MEDICATION(S)
TAZAROTENE 0.05% CREAM, TAZAROTENE 0.05% GEL, TAZAROTENE 0.1% CREAM, TAZAROTENE 0.1% GEL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Requested agent will be used for cosmetic purposes

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of the following: A. Patient has an FDA labeled indication for the requested agent OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOPICAL RETINOIDS PA - TRETINOIN

MEDICATION(S)
TRETINOIN 0.01% GEL, TRETINOIN 0.025% CREAM, TRETINOIN 0.025% GEL, TRETINOIN 0.05% CREAM, TRETINOIN 0.1% CREAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Requested agent will be used for cosmetic purposes

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. ONE of the following: A. Patient has an FDA labeled indication for the requested agent OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TRELSTAR PA

MEDICATION(S)
TRELSTAR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. BOTH of the following: i. Patient is NOT currently being treated with the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND 3. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

TRIENTINE PA

MEDICATION(S)
TRIENTINE HCL 250 MG CAPSULE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has a diagnosis of Wilson's disease confirmed by ONE of the following: A. Confirmation of genetic mutation of the ATP7B gene OR B. Patient has TWO or more of the following: i. Presence of hepatic abnormality (e.g., acute liver failure, cirrhosis, fatty liver) ii. Presence of Kayser-Fleischer rings iii. Serum ceruloplasmin level less than 20 mg/dL iv. Basal urinary copper excretion greater than 40 mcg/24 hours or the testing laboratory's upper limit of normal v. Hepatic parenchymal copper content greater than 40 mcg/g dry weight vi. Presence of neurological symptoms (e.g., dystonia, hypertonia, rigidity with tremors, dysarthria, muscle spasms, dysphasia, polyneuropathy, dysautonomia) AND 2. ONE of the following: A. Patient has tried and had an inadequate response to penicillamine OR B. Patient has an intolerance or hypersensitivity to penicillamine OR C. Patient has an FDA labeled contraindication to penicillamine Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of Wilson's disease AND 3. Patient has had clinical benefit with the requested agent as evidenced by ONE of the following: A. Improvement and/or stabilization in hepatic abnormality OR B. Reduction in Kayser-Fleischer rings OR C. Improvement and/or stabilization in neurological symptoms (e.g., dystonia, hypertonia, rigidity with tremors, dysarthria, muscle spasms, dysphasia, polyneuropathy, dysautonomia) OR D. Basal urinary copper excretion greater than 200 mcg/24 hours

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist,

neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TRIKAFTA PA

MEDICATION(S)
TRIKAFTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of cystic fibrosis AND 2. ONE of the following: A. Patient has the presence of the F508del mutation in at least ONE allele (heterozygous OR homozygous) of the CFTR gene confirmed by genetic testing OR B. Patient has ONE of the CFTR gene mutations or a mutation in the CFTR gene that is responsive based on in vitro data, as indicated in the FDA label, confirmed by genetic testing OR C. Patient has another CFTR gene mutation(s) that is responsive to the requested agent, as indicated in the FDA label, confirmed by genetic testing AND 3. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of cystic fibrosis AND 3. Patient has had improvement or stabilization with the requested agent [e.g., improvement in FEV1 from baseline, increase in weight/BMI, improvement from baseline Cystic Fibrosis Questionnaire-Revised (CFQ-R) Respiratory Domain score, improvements in respiratory symptoms (cough, sputum production, and difficulty breathing), and/or reduced number of pulmonary exacerbations] AND 4. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication

AGE RESTRICTION
Patient is within the FDA labeled age for the requested agent

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cystic fibrosis, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

TRULICITY PA

MEDICATION(S)
TRULICITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Requested agent will be used for weight loss alone

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR C. ALL of the following: i. Patient does NOT have any FDA labeled contraindications to the requested agent AND ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

TYMLOS PA

MEDICATION(S)
TYMLOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. Patient (pt) has ONE of the following: A. Postmenopausal osteoporosis OR B. Pt's sex is male with osteoporosis AND 2. BOTH of the following: A. Pt's diagnosis was confirmed by ONE of the following: i. A fragility fracture in the hip or spine OR ii. A T-score of -2.5 or lower OR iii. A T-score of -1.0 to -2.5 AND ONE of the following: a. A fragility fracture of proximal humerus, pelvis, or distal forearm OR b. A FRAX 10-year probability for major osteoporotic fracture of 20% or greater OR c. A FRAX 10-year probability of hip fracture of 3% or greater AND B. ONE of the following: i. Pt is at a very high fracture risk as defined by ONE of the following: a. Pt had a recent fracture (within the past 12 months) OR b. Pt had fractures while on FDA approved osteoporosis therapy OR c. Pt has had multiple fractures OR d. Pt had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR e. Pt has a very low T-score (less than -3.0) OR f. Pt is at high risk for falls or has a history of injurious falls OR g. Pt has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm OR ii. ONE of the following: a. Pt has tried and had an inadequate response to a bisphosphonate OR b. Pt has an intolerance or hypersensitivity to a bisphosphonate OR c. Pt has an FDA labeled contraindication to a bisphosphonate AND 3. Pt will NOT be using the requested agent in combination with a bisphosphonate, denosumab (e.g., Prolia, Xgeva), romosozumab-aqqg, or another parathyroid hormone analog (e.g., teriparatide) for the requested indication AND 4. The requested dose is within FDA labeled dosing for the requested indication AND 5. The total cumulative duration of treatment with teriparatide and Tymlos (abaloparatide) has not exceeded 2 years

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

No prior Tymlos and/or teriparatide use approve 2 years, Prior use - see Other Criteria

OTHER CRITERIA

Prior Tymlos and/or teriparatide use approve remainder of 2 years of total cumulative therapy

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

UREA CYCLE DISORDERS PA - SODIUM PHENYLBUTYRATE

MEDICATION(S)
SODIUM PHENYLBUTYRATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require BOTH of the following: 1. Patient has a diagnosis of ONE of the following: a. Urea cycle disorder with neonatal-onset involving deficiencies of carbamylphosphate synthetase, ornithine transcarbamylase, or argininosuccinic acid synthetase OR b. Urea cycle disorder with late-onset and history of hyperammonemic encephalopathy involving deficiencies of carbamylphosphate synthetase, ornithine transcarbamylase, or argininosuccinic acid synthetase AND 2. The requested dose is within FDA labeled dosing for the requested indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist, metabolic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

VALCHLOR PA

MEDICATION(S)
VALCHLOR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. BOTH of the following: i. ONE of the following: a. BOTH of the following: 1. Patient has a diagnosis of Stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma AND 2. Patient's medication history indicates use of at least ONE prior skin-directed therapy (e.g., topical corticosteroid) OR b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist, oncologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 3. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. BOTH of the following: i. Patient has had clinical benefit with the requested agent AND ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist, oncologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VEOZAH PA

MEDICATION(S)
VEOZAH

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VIBERZI PA

MEDICATION(S)
VIBERZI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has a diagnosis of irritable bowel syndrome with diarrhea (IBS-D)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VORICONAZOLE PA

MEDICATION(S)
VORICONAZOLE, VORICONAZOLE (HPBCD)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of invasive Aspergillus OR B. Patient has a serious infection caused by Scedosporium apiospermum or Fusarium species OR C. BOTH of the following: i. ONE of the following: 1. Patient has a diagnosis of esophageal candidiasis OR 2. Patient has a diagnosis of candidemia in nonneutropenic patient OR 3. Patient has a diagnosis of other deep tissue Candida infections AND ii. ONE of the following: 1. Patient has tried and had an inadequate response to fluconazole or an alternative antifungal agent OR 2. Patient has an intolerance or hypersensitivity to fluconazole or an alternative antifungal agent OR 3. Patient has an FDA labeled contraindication to fluconazole or an alternative antifungal agent OR D. Patient has a diagnosis of blastomycosis AND ONE of the following: i. Patient has tried and had an inadequate response to itraconazole OR ii. Patient has an intolerance or hypersensitivity to itraconazole OR iii. Patient has an FDA labeled contraindication to itraconazole OR E. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida AND patient is severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR F. Patient has another indication that is supported in CMS approved compendia for the requested agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be 1 month for esophageal candidiasis, 6 months for all other indications

OTHER CRITERIA
Criteria for renewal approval require BOTH of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of invasive Aspergillus, a serious infection caused by Scedosporium apiospermum or Fusarium species, esophageal candidiasis, candidemia in nonneutropenic patient, other deep tissue Candida infections, or blastomycosis and patient has continued indicators of active disease (e.g., biomarkers in serum assay, microbiologic cultures, radiographic evidence) OR B. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida and patient continues to be severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR C. BOTH of the following: i. Patient has another indication that is supported in CMS approved compendia for the requested agent AND ii. Patient has had clinical benefit with the requested agent

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VOSEVI PA

MEDICATION(S)
VOSEVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. Patient has a diagnosis of hepatitis C confirmed by serological markers AND 2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND 3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND 4. The requested dose is within FDA labeled dosing or supported in AASLD/IDSA guideline dosing for the requested indication AND 5. If genotype 1, the patient's subtype has been identified and provided

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

VOWST PA

MEDICATION(S)
VOWST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. The requested agent will be used to prevent the recurrence of Clostridioides difficile infection (CDI) AND 2. Patient has had a confirmed diagnosis of recurrent CDI as defined by greater than or equal to 3 episodes of CDI in a 12 month period AND 3. Patient has completed a standard of care antibiotic regimen (e.g., vancomycin, fidaxomicin) for recurrent CDI at least 2 to 4 days before initiating treatment with the requested agent AND 4. Patient will NOT be using the requested agent in combination with any antibiotic regimen for any indication

AGE RESTRICTION
Patient is within the FDA labeled age for the requested agent

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., infectious disease, gastroenterologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

XDEMVY PA

MEDICATION(S)
XDEMVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has a diagnosis of Demodex blepharitis AND BOTH of the following: A. Patient has ONE of the following signs of Demodex infestation: i. Collarettes (cylindrical dandruff at the eyelash base) OR ii. Lid margin erythema or edema OR iii. Conjunctival injection OR iv. Eyelash misdirection/irregularity AND B. Patient has ONE of the following symptoms of Demodex infestation: i. Blurred/fluctuating vision OR ii. Discharge or crusting on lashes OR iii. Dryness OR iv. Foreign body sensation OR v. Itching OR vi. Pain/burning OR vii. Watering/tearing

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a specialist in the area of the patient's diagnosis (e.g., infectious disease, ophthalmologist, optometrist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION
Approval will be for 6 weeks

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

XERMELO PA

MEDICATION(S)
XERMELO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of carcinoid syndrome diarrhea AND 2. Patient has tried and had an inadequate response to treatment with a somatostatin analog (e.g., octreotide) AND 3. The requested agent will be used in combination with a somatostatin analog (e.g., octreotide) Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of carcinoid syndrome diarrhea AND 3. Patient has had clinical benefit with the requested agent (e.g., reduction in the average number of daily bowel movements) AND 4. The requested agent will be used in combination with a somatostatin analog (e.g., octreotide)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

XGEVA PA

MEDICATION(S)
XGEVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require ALL of the following: 1. ONE of the following: A. Patient has a diagnosis of multiple myeloma AND BOTH of the following: i. The requested agent will be used for the prevention of skeletal-related events AND ii. ONE of the following: 1. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR 2. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR 3. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR B. Patient has a diagnosis of prostate cancer AND ALL of the following: i. The requested agent will be used for the prevention of skeletal-related events AND ii. Patient has bone metastases AND iii. ONE of the following: 1. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR 2. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR 3. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR Criteria continues: see Other Criteria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA

C. Patient has a solid tumor cancer diagnosis (e.g., thyroid, non-small cell lung, kidney cancer, or breast cancer) AND ALL of the following: i. The requested agent will be used for the prevention of skeletal-related events AND ii. Patient has bone metastases AND iii. ONE of the following: 1. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR 2. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR 3. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR D. Patient has a diagnosis of giant cell tumor of bone AND ONE of the following: i. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR ii. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR iii. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR E. Patient has a diagnosis of hypercalcemia of malignancy AND 2. Patient will NOT be using the requested agent in combination with another form of denosumab AND 3. The requested dose is within FDA labeled dosing for the requested indication

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

XIFAXAN 550 MG TABLET PA

MEDICATION(S)
XIFAXAN 550 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
FDA labeled contraindications to the requested agent

REQUIRED MEDICAL INFORMATION
Criteria for approval require the following: 1. Patient has ONE of the following: a. A diagnosis of irritable bowel syndrome with diarrhea (IBS-D) OR b. A diagnosis of hepatic encephalopathy [reduction in risk of overt hepatic encephalopathy (HE) recurrence]

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval will be for 12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

XOLAIR PA

MEDICATION(S)
XOLAIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require ALL of the following: 1. ONE of the following: A. Patient has a diagnosis of moderate to severe persistent asthma AND ALL of the following: i. ONE of the following: a. Patient is 6 to less than 12 years of age AND BOTH of the following: 1. Patient's pretreatment IgE level is 30 IU/mL to 1300 IU/mL AND 2. Patient's weight is 20 kg to 150 kg OR b. Patient is 12 years of age or over AND BOTH of the following: 1. Patient's pretreatment IgE level is 30 IU/mL to 700 IU/mL AND 2. Patient's weight is 30 kg to 150 kg AND ii. Allergic asthma has been confirmed by a positive skin test or in vitro reactivity test to a perennial aeroallergen AND iii. ONE of the following: a. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent OR b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an asthma control therapy OR B. Patient has a diagnosis of chronic idiopathic urticaria (CSU) AND BOTH of the following: i. Patient has had over 6 weeks of hives and itching AND ii. ONE of the following: a. Patient has tried and had an inadequate response to maximum tolerable H1 antihistamine therapy OR b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to H1 antihistamine therapy OR C. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND BOTH of the following: i. ONE of the following: a. Patient has tried and had an inadequate response to an intranasal corticosteroid OR b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an intranasal corticosteroid AND ii. ONE of the following: a. The requested agent will be used in combination with an intranasal corticosteroid OR b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an intranasal corticosteroid OR Initial criteria continues: see Other Criteria

AGE RESTRICTION
For diagnosis of moderate to severe persistent asthma, patient is 6 years of age or over. For diagnosis

of chronic idiopathic urticaria (CSU), patient is 12 years of age or over. For diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP), patient is 18 years of age or over. For diagnosis of IgE-mediated food allergy, patient is 1 year of age or over.

PRESCRIBER RESTRICTION

Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, hematologist, immunologist, oncologist, otolaryngologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

COVERAGE DURATION

Approval will be 6 months for initial, 12 months for renewal

OTHER CRITERIA

D. Patient has a diagnosis of IgE-mediated food allergy AND ALL of the following: i. Patient is using the requested agent for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods AND ii. IgE-mediated food allergy has been confirmed by an allergy diagnostic test (e.g., skin prick test, serum specific IgE test, oral food challenge) AND iii. Patient will avoid known food allergens while treated with the requested agent AND iv. The requested agent will NOT be used for the emergency treatment of allergic reactions, including anaphylaxis AND 2. Patient will NOT be using the requested agent in combination with Dupixent or an injectable Interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Fasenra, Nucala) for the requested indication AND 3. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of moderate to severe persistent asthma AND BOTH of the following: i. Patient has had clinical benefit with the requested agent AND ii. ONE of the following: a. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent OR b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an asthma control therapy OR B. Patient has a diagnosis of chronic idiopathic urticaria (CSU) AND the following: a. Patient has had clinical benefit with the requested agent OR C. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND the following: a. Patient has had clinical benefit with the requested agent OR D. Patient has a diagnosis of IgE-mediated food allergy AND ALL of the following: a. Patient is using the requested agent for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods AND b. Patient has had clinical benefit with the requested agent AND c. Patient will avoid known food allergens while treated with the requested agent AND d. The requested agent will NOT be used for the emergency treatment of allergic reactions, including anaphylaxis AND 3. Patient will NOT be using the requested agent in combination with Dupixent or an injectable interleukin 5 (IL-5)

inhibitor (e.g., Cinqair, Fasenra, Nucala) for the requested indication AND 4. The requested dose is within FDA labeled dosing for the requested indication

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ZTALMY PA

MEDICATION(S)
ZTALMY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria for initial approval require BOTH of the following: 1. Patient has a diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. BOTH of the following: i. Patient's diagnosis has been confirmed with genetic testing indicating variant in CDKL5 gene AND ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) AND 3. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. BOTH of the following: i. Patient has had clinical benefit with the requested agent AND ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

AGE RESTRICTION
Patient is within the FDA labeled age for the requested agent

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Approval will be for 12 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A