2026 Prior Authorization (PA) Criteria

Certain drugs require prior authorization from EmblemHealth Medicare PDP Medicare Plans. This means that your doctor must contact us to get approval before prescribing the drug to you. If your doctor does not get prior approval, the drug may not be covered. This list also includes drugs that may be covered under Medicare Part B or Part D depending on how the drugs are used or administered. If your drug is on this list, your doctor should call us and to provide information describing the use and administration of the drug so we can advise on whether the drug will be covered.

To see if your drug is on the list refer to the table of contents located on the next page of this document for the medication you are looking for.

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2026 PRIOR AUTHORIZATION CRITERIA

TABLE OF CONTENTS

Abiraterone Acetate 223
Abirtega 223
Accutane 129
Actemra 44
Actemra Actpen 44
Actimmune 10
Acyclovir 11
Adempas 197
Aimovig 12
Akeega 223
Alcohol Swabs 13
Alecensa 223
Alosetron Hcl 14
Alunbrig 223
Ambrisentan 199
Amnesteem 129
Apomorphine Hcl 25
Aranesp Albumin Free 99
Arcalyst 26
Arikayce 27
Aripiprazole 23
Aripiprazole Odt 23
Armodafinil 28
Asenapine Maleate Sl 23
Atovaquone 31
Attruby 32
Augtyro 223
Austedo 33
Austedo Xr 33
Austedo Xr Patient Titration Kit 33
Avmapki Fakzynja Co-Pack 223
Avonex 157
Avonex Pen 157
Ayvakit 223
Balversa 223
Belsomra 34
Benlysta SC 36
Besremi 223
Betaseron 158
Bexarotene Capsules 223
Bexarotene Gel 42

Bonsity 242
Bosentan 201
Bosulif 223
Bosutinib 223
Braftovi 223
Brukinsa 223
Budesonide Dr (Entocort) 69
Budesonide Er (Uceris) 70
Bysanti 23
Cabometyx 223
Calquence 223
Caprelsa 223
Carglumic Acid 71
Cavhanza 223
Cayston 72
Chenodal 73
Chlorpromazine Hcl 23
Cinacalcet Hcl 74
Claravis 129
Clobazam 37
Clorazepate Dipotassium 38
Clozapine 23
Clozapine Odt 23
Cobenfy 75
Cobenfy Starter Pack 75
Cometriq 223
Copiktra 223
Corlanor 82
Cosentyx 46
Cosentyx Sensoready Pen 46
Cosentyx Unoready 46
Cotellic 223
Cresemba 83
Cyproheptadine Hcl 120
Cystagon 85
Cystaran 84
Dalfampridine Er 86
Danazol 16
Danziten 223
Dasatinib 223
Daurismo 223
Dayvigo 87
Deferasirox (Exjade) 127
Deferasirox (Jadenu) 128
Depo-Testosterone 17
Dexmethylphenidate Hcl (Focalin) 110
Diazepam 39
Diazepam Intensol 39

Diclofenac Sodium (Pennsaid) 247
Diclofenac Sodium Gel 3% 246
Dicyclomine Hcl 120
Dihydroergotamine Mesylate Spray 154
Dimethyl Fumarate 159
Dimethyl Fumarate Starterpack 159
Diphenoxylate/Atropine 120
Doptelet Cap 88
Doptelet Tab 89
Droxidopa 91
Dupixent 92
Eligard 137
Eltrombopag 195
Emgality 95
Emsam 96
Enbrel 48
Enbrel Mini 48
Enbrel Sureclick 48
Ensacove 223
Entyvio Pen 50
Epidiolex 98
Erivedge 223
Erleada 223
Erlotinib Hcl 223
Eucrisa 29
Everolimus 223
Eysuvis 104
Fanapt 23
Fanapt Pack A 23
Fanapt Pack B 23
Fanapt Pack C 23
Fasenra 105
Fasenra Pen 105
Fentanyl Citrate Oral Transmucosal 107
Fentanyl Patch 176
Fingolimod Hcl 160
Fintepla 108
Firmagon 124
Flucytosine 109
Fluphenazine Decanoate 23
Fluphenazine Hcl 23
Fotivda 223
Fruzaqla 223
Fulphila 77
Gammagard Liquid 111
Gammagard Liquid Erc 111
Gamunex-C 111
Gauze Pads 113

Gavreto 223
Gefitinib 223
Gilotrif 223
Glatiramer Acetate 161
Glatopa 161
Gomekli 223
Granix 78
Hadlima 51
Hadlima Pushtouch 51
Haegarda 116
Haloperidol 23
Haloperidol Decanoate 23
Haloperidol Lactate 23
Hernexeos 223
Hydroxyzine Hcl 120
Hyrnuo 223
Ibrance 223
Ibtrozi 223
Icatibant Acetate 118
Iclusig 224
Idhifa 224
Imatinib Mesylate 224
Imbruvica 224
Imiquimod Cream 5% 121
Imkeldi 224
Inbrija 122
Ingrezza 123
Inluriyo 224
Inlyta 224
Inqovi 224
Inrebic 224
Insulin Pen Needle 125
Insulin Syringe/Needle 126
Isotretinoin 129
Itovebi 224
Ivabradine Hcl 82
Ivermectin Tablet 130
Iwilfin 224
Jakafi 224
Jaypirca 224
Jubbonti 131
Kalydeco 135
Kerendia 136
Kesimpta 162
Kisqali 224
Kisqali Femara 224
Komzifti 224
Koselugo 224

Krazati 224
Lapatinib Ditosylate 224
Lazcluze 224
Lenalidomide 224
Lenvima 224
Leuprolide Acetate 137
L-glutamine 138
Lidocaine Ointment 139
Lidocaine Patch 140
Lidocaine Solution 141
Lidocaine/Prilocaine 142
Lidocan 140
Lifyorli 224
Linezolid 143
Lonsurf 224
Lorazepam 40
Lorazepam Intensol 40
Lorbrena 224
Loxapine 23
Lumakras 224
Lumryz 145
Lumryz Starter Pack 145
Lupron Depot 137
Lupron Depot-Ped 137
Lurasidone Hcl 23
Lybalvi 23
Lynparza 224
Lytgobi 224
Matulane 224
Mavyret 147
Mekinist 224
Mektovi 224
Memantine Hcl 149
Memantine Hcl Er 148
Memantine Hcl Titration Pak 149
Methylphenidate Hcl (Methylin) 150
Methylphenidate Hcl (Ritalin) 219
Methylphenidate Hcl Er Tablet 151
Miebo 152
Mifepristone 153
Miglustat 239
Modafinil 155
Modeyso 224
Molindone Hcl 23
Morphine Sulfate Er 178
Mounjaro 156
Nerlynx 224
Nexletol 165

Nexlizet 167
Nilotinib 224
Ninlaro 224
Nintedanib 173
Nivestym 79
Nubeqa 224
Nuedexta 169
Nuplazid 170
Nurtec 171
Octreotide Acetate 233
Odomzo 224
Ogsiveo 224
Ojemda 224
Ojjaara 224
Olanzapine 23
Olanzapine Odt 23
Omnipod Kit 174
Omnipod Pods 174
Omnitrope 114
Onureg 224
Opipza 23
Orenitram 203
Orenitram Titration Kit 203
Orgovyx 224
Orkambi 182
Orserdu 224
Osenvelt 183
Otezla 185
Otezla Xr 187
Ozempic Inj 189
Ozempic Tab 221
Paliperidone Er 23
Panretin 190
Pazopanib Hcl 225
Pegasys 191
Pemazyre 225
Perphenazine 23
Pimozide 23
Piqray 225
Pirfenidone 192
Plegridy 163
Plegridy Starter Pack 163
Pomalidomide 225
Posaconazole 193
Posaconazole Dr 193
Procrit 100
Prolastin-C 15
Pyrimethamine 212

Pyrukynd 213
Pyrukynd Taper Pack 213
Pyzchiva 52
Qinlock 225
Quetiapine Fumarate 23
Quetiapine Fumarate Er 23
Quinine Sulfate 214
Repatha 215
Repatha Sureclick 215
Retacrit 102
Retevmo 225
Revcovi 217
Revuforj 225
Rexulti 23
Rezdiffra 218
Rezlidhia 225
Rinvoq Lq 54
Rinvoq Tablet 55
Risperidone 23
Risperidone Odt 23
Roflumilast 220
Romvimza 225
Rozlytrek 225
Rubraca 225
Rybelsus 221
Rydapt 225
Sajazir 118
Sapropterin Dihydrochloride 222
Scemblix 225
Scopolamine 120
Secuado 23
Signifor 228
Sildenafil Citrate 205
Simlandi 59
Sivextro 229
Skyrizi 61
Skyrizi Pen 61
Sodium Oxybate 231
Sodium Phenylbutyrate 256
Somavert 235
Sorafenib 225
Steqeyma 63
Stivarga 225
Stoboclo 236
Sunitinib Malate 225
Sympazan 41
Tabrecta 225
Tacrolimus 30

Tadalafil 2.5Mg, 5Mg 35
Tadalafil Tablet 20Mg 207
Tafinlar 225
Tagrisso 225
Talzenna 225
Tasimelteon 241
Tazarotene 248
Tepmetko 225
Teriparatide 242
Testosterone 21
Testosterone Cypionate 17
Testosterone Enanthate 19
Testosterone Pump 21
Tetrabenazine 244
Thalomid 225
Thioridazine Hcl 23
Thiothixene 23
Tibsovo 225
Tobramycin Neb 245
Tolvaptan (Jynarque) 134
Torpenz 225
Tramadol Hcl Er 180
Trelstar Mixject 250
Tremfya 65
Tretinoin Capsule 225
Tretinoin Cream, Gel 249
Tridacaine Patch 140
Trientine Hcl 251
Trifluoperazine Hcl 23
Trihexyphenidyl Hcl 120
Trikafta 252
Trilitas 248
Trulicity 253
Truqap 225
Tukysa 225
Turalio 225
Tyenne 67
Tymlos 254
Udenyca 80
Udenyca Onbody 80
Ustekin-Aekn 57
Valchlor 257
Vanflyta 225
Venclexta 225
Venclexta Starting Pack 225
Ventavis 209
Veozah 259
Veppanu 225

Versacloz 23
Verzenio 225
Viberzi 260
Vitrakvi 225
Vizimpro 225
Vonjo 225
Voranigo 225
Voriconazole 261
Vosevi 263
Vowst 264
Vumerity 164
Welireg 225
Winrevair 211
Wyost 265
Xalkori 225
Xdemvy 267
Xermelo 268
Xifaxan 550Mg 269
Xiidra 175
Xolair 270
Xospata 225
Xpovio 225
Xtandi 225
Yargesa 239
Yulithira 226
Zejula 226
Zelboraf 226
Zelvysia 222
Zenatane 129
Ziextenzo 81
Ziprasidone Mesylate 23
Zokinvy 273
Zolinza 226
Ztalmy 274
Zydelig 226
Zykadia 226

Prior Authorization Group Description:
Actimmune PA
Drug Name(s)
Actimmune
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Acyclovir Topical PA
Drug Name(s)
Acyclovir
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Aimovig PA
Drug Name(s)
Aimovig
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Alcohol Swabs PA
Drug Name(s)
Alcohol Swabs
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Alosetron PA
Drug Name(s)
Alosetron Hcl
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Alpha-1-Proteinase Inhibitor PA – Prolastin-C
Drug Name(s)
Prolastin-C
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Anabolic Steroid PA – Danazol
Drug Name(s)
Danazol
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Androgen Injectable PA - testosterone cypionate
Drug Name(s)
Depo-Testosterone
Testosterone Cypionate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:

Coverage Duration:
Approval will be 6 months for delayed puberty, 12 months for all other indications
Other Criteria:

Prior Authorization Group Description:
Androgen Injectable PA - testosterone enanthate
Drug Name(s)
Testosterone Enanthate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:

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

Prior Authorization Group Description:
Androgen Topical PA
Drug Name(s)
Testosterone
Testosterone Pump
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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 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:

Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Antipsychotics PA
Drug Name(s)
Aripiprazole
Aripiprazole Odt
Asenapine Maleate Sl
Bysanti
Chlorpromazine Hcl
Clozapine
Clozapine Odt
Fanapt
Fanapt Pack A
Fanapt Pack B
Fanapt Pack C
Fluphenazine Decanoate
Fluphenazine Hcl
Haloperidol
Haloperidol Decanoate
Haloperidol Lactate
Loxapine
Lurasidone Hcl
Lybalvi
Molindone Hcl
Olanzapine
Olanzapine Odt
Opipza
Paliperidone Er
Perphenazine
Pimozide
Quetiapine Fumarate
Quetiapine Fumarate Er
Rexulti
Risperidone
Risperidone Odt
Secuado
Thioridazine Hcl
Thiothixene
Trifluoperazine Hcl
Versacloz
Ziprasidone Mesylate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:

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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Apomorphine Inj PA
Drug Name(s)
Apomorphine Hcl
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Arcalyst PA
Drug Name(s)
Arcalyst
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Arikayce PA
Drug Name(s)
Arikayce
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Armodafinil PA
Drug Name(s)
Armodafinil
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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 Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Atopic Dermatitis PA – Eucrisa
Drug Name(s)
Eucrisa
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Atopic Dermatitis PA – Tacrolimus
Drug Name(s)
Tacrolimus
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Atovaquone PA
Drug Name(s)
Atovaquone
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Attruby PA
Drug Name(s)
Attruby
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Austedo PA
Drug Name(s)
Austedo
Austedo Xr
Austedo Xr Patient Titration Kit
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Belsomra PA
Drug Name(s)
Belsomra
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benign Prostatic Hyperplasia PA – Tadalafil
Drug Name(s)
Tadalafil 2.5Mg, 5Mg
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benlysta SC PA
Drug Name(s)
Benlysta SC
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 5 years of age or over.
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Clobazam
Drug Name(s)
Clobazam
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Clorazepate
Drug Name(s)
Clorazepate Dipotassium
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Diazepam
Drug Name(s)
Diazepam
Diazepam Intensol
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Lorazepam
Drug Name(s)
Lorazepam
Lorazepam Intensol
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Sympazan
Drug Name(s)
Sympazan
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Bexarotene Gel PA
Drug Name(s)
Bexarotene Gel
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Biologic Immunomodulators PA – Actemra
Drug Name(s)
Actemra
Actemra Actpen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Biologic Immunomodulators PA – Cosentyx
Drug Name(s)
Cosentyx
Cosentyx Sensoready Pen
Cosentyx Unoready
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Biologic Immunomodulators PA – Enbrel
Drug Name(s)
Enbrel
Enbrel Mini
Enbrel Sureclick
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 12 months

Other Criteria:

Use of ONE preferred agent (Hadlima or 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

Prior Authorization Group Description:
Biologic Immunomodulators PA – Entyvio SC
Drug Name(s)
Entyvio Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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 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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Biologic Immunomodulators PA – Hadlima
Drug Name(s)
Hadlima
Hadlima Pushtouch
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Biologic Immunomodulators PA – Pyzchiva
Drug Name(s)
Pyzchiva
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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 moderate Crohn's disease, severe Crohn's disease, 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

Prior Authorization Group Description:
Biologic Immunomodulators PA – Rinvoq Solution
Drug Name(s)
Rinvoq Lq
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of ONE preferred TNF (Hadlima or 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

Prior Authorization Group Description:
Biologic Immunomodulators PA – Rinvoq Tablet
Drug Name(s)
Rinvoq Tablet
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:

Prescriber Restrictions:
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 (Hadlima or Simlandi) is required for diagnoses of ankylosing spondylitis, rheumatoid arthritis, adult psoriatic arthritis, or juvenile idiopathic arthritis

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, giant cell arteritis, moderate Crohn's disease, severe Crohn's disease, moderate ulcerative colitis, or severe ulcerative colitis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Selarsdi
Drug Name(s)
Ustekin-Aekn
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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 moderate Crohn's disease, severe Crohn's disease, 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

Prior Authorization Group Description:
Biologic Immunomodulators PA - Simlandi
Drug Name(s)
Simlandi
Indications:
All FDA-Approved Indications
Off-Label Uses:
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:
Prescriber Restrictions:
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, or juvenile idiopathic arthritis

NO prerequisites are required for diagnoses of ankylosing spondylitis, moderate Crohn's disease, severe Crohn's disease, 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

Prior Authorization Group Description:
Biologic Immunomodulators PA – Skyrizi
Drug Name(s)
Skyrizi
Skyrizi Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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 moderate Crohn's disease, severe Crohn's disease, 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

Prior Authorization Group Description:
Biologic Immunomodulators PA – Steqeyma
Drug Name(s)
Steqeyma
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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 moderate Crohn's disease, severe Crohn's disease, 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

Prior Authorization Group Description:
Biologic Immunomodulators PA – Tremfya
Drug Name(s)
Tremfya
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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 moderate Crohn's disease, severe Crohn's disease, 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

Prior Authorization Group Description:
Biologic Immunomodulators PA - Tyenne
Drug Name(s)
Tyenne
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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 cytokine release syndrome or systemic juvenile idiopathic arthritis

Prior Authorization Group Description:
Budesonide Oral ER PA – Entocort
Drug Name(s)
Budesonide Dr (Entocort)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Budesonide Oral ER PA – Uceris
Drug Name(s)
Budesonide Er (Uceris)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:

Carglumic PA

Drug Name(s)

Carglumic Acid

Indications:

All FDA-Approved Indications, Some Medically-Accepted Indications.

Off-Label Uses:

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

Exclusion Criteria:

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:

Prescriber Restrictions:

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:

Prior Authorization Group Description:
Cayston PA
Drug Name(s)
Cayston
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Chenodal PA
Drug Name(s)
Chenodal
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Cinacalcet PA
Drug Name(s)
Cinacalcet Hcl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Cobenfy PA
Drug Name(s)
Cobenfy
Cobenfy Starter Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Colony Stimulating Factors PA – Fulphila
Drug Name(s)
Fulphila
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Granix
Drug Name(s)
Granix
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Nivestym
Drug Name(s)
Nivestym
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Udenyca
Drug Name(s)
Udenyca
Udenyca Onbody
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Ziextenzo
Drug Name(s)
Ziextenzo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:

Corlanor PA

Drug Name(s)

Corlanor

Ivabradine Hcl

Indications:

All FDA-Approved Indications.

Off-Label Uses:

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:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Cresemba PA
Drug Name(s)
Cresemba
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Cystaran PA
Drug Name(s)
Cystaran
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Cystinosis Agents PA – Cystagon
Drug Name(s)
Cystagon
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Dalfampridine PA
Drug Name(s)
Dalfampridine Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. Patient has a diagnosis of multiple sclerosis (MS)

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. Patient has had improvements or stabilization from baseline in timed walking speed (timed 25-foot walk)
Age Restriction:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Dayvigo PA
Drug Name(s)
Dayvigo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Doptelet Capsule PA
Drug Name(s)
Doptelet Cap
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of persistent or chronic immune (idiopathic) thrombocytopenia (ITP) AND
2. ONE of the following:
    A. Patient has tried and had an insufficient response to a corticosteroid, another thrombopoietin receptor agonist (e.g., eltrombopag), or immunoglobulin (IVIg or anti-D) OR
    B. Patient has an intolerance or hypersensitivity to a corticosteroid, another thrombopoietin receptor agonist (e.g., eltrombopag), or immunoglobulin (IVIg or anti-D) OR
    C. Patient has an FDA labeled contraindication to a corticosteroid, another thrombopoietin receptor agonist (e.g., eltrombopag), or immunoglobulin (IVIg or anti-D) OR
    D. Patient has had an insufficient response to a splenectomy 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 persistent or chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following:
    A. Patient's platelet count is 50 x 10^9/L or greater OR
    B. Patient's platelet count has increased sufficiently to avoid clinically significant bleeding AND
3. 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 Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Doptelet PA
Drug Name(s)
Doptelet Tab
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of thrombocytopenia AND ALL of the following:
        i. Patient has chronic liver disease AND
        ii. Patient has a platelet count less than 50 X 10^9/L AND
        iii. Patient is scheduled to undergo a procedure with an associated risk of bleeding (e.g., gastrointestinal endoscopy, liver biopsy, bronchoscopy, dental procedure) AND
        iv. The length of therapy of the requested agent is within the FDA labeled duration for the requested indication OR
    B. Patient has a diagnosis of persistent or chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following:
        i. Patient has tried and had an insufficient response to a corticosteroid, another thrombopoietin receptor agonist (e.g., eltrombopag), or immunoglobulin (IVIg or anti-D) OR
        ii. Patient has an intolerance or hypersensitivity to a corticosteroid, another thrombopoietin receptor agonist (e.g., eltrombopag), or immunoglobulin (IVIg or anti-D) OR
        iii. Patient has an FDA labeled contraindication to a corticosteroid, another thrombopoietin receptor agonist (e.g., eltrombopag), or immunoglobulin (IVIg or anti-D) OR
        iv. Patient has had an insufficient response to a splenectomy AND
2. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Initial (I) 6 mo ITP, Renewal (R) 12 mo ITP. I & R 1 mo thrombocytopenia w/chronic liver disease
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 thrombocytopenia AND ALL of the following:
        i. Patient has chronic liver disease AND
        ii. Patient has a platelet count less than 50 X 10^9/L AND

iii. Patient is scheduled to undergo a procedure with an associated risk of bleeding (e.g., gastrointestinal endoscopy, liver biopsy, bronchoscopy, dental procedure) AND

iv. The length of therapy of the requested agent is within the FDA labeled duration for the requested indication OR

B. Patient has a diagnosis of persistent or chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following:

i. Patient's platelet count is 50 x 10^9/L or greater OR

ii. Patient's platelet count has increased sufficiently to avoid clinically significant bleeding AND

3. The requested dose is within FDA labeled dosing for the requested indication

Prior Authorization Group Description:
Droxidopa PA
Drug Name(s)
Droxidopa
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Dupixent PA
Drug Name(s)
Dupixent
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of:
    A. Patient (pt) has a diagnosis (dx) of allergic fungal rhinosinusitis (AFRS) AND the following:
        i. Pt has a history of sino-nasal surgery (e.g., endoscopic sinus surgery) for the treatment of AFRS OR
    B. Pt has a dx of moderate-to-severe atopic dermatitis AND ALL of:
        i. ONE of:
            a. Pt has tried and failed a topical steroid (e.g., triamcinolone) OR
            b. Pt has an intolerance, hypersensitivity, or an FDA labeled contraindication to a topical steroid AND
        ii. For pts 2 years of age or over, ONE of:
            a. Pt has tried and failed a topical calcineurin inhibitor (e.g., tacrolimus) OR
            b. Pt has an intolerance, hypersensitivity, or an FDA labeled contraindication to a topical calcineurin inhibitor AND
        iii. Pt will NOT be using the requested agent in combination with another biologic agent or a JAK inhibitor for the requested indication OR
    C. Pt has a dx of moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid dependent asthma AND BOTH of:
        i. Pt 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. Pt 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
    D. Pt has a dx of bullous pemphigoid (BP) OR
    E. Pt has a dx of chronic rhinosinusitis with nasal polyposis (CRSwNP) AND the following:
        i. BOTH of:
            a. ONE of:
                1. Pt has tried and had an inadequate response to an oral systemic corticosteroid AND an intranasal corticosteroid (e.g., fluticasone) OR
                2. Pt has an intolerance, hypersensitivity, or an FDA labeled contraindication to an oral systemic corticosteroid AND an intranasal corticosteroid AND

Initial criteria continues: see Other Criteria
Age Restriction:

For dx of moderate-to-severe atopic dermatitis, pt is 6 months of age or over. For dx of moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid dependent asthma, pt is 6 years of age or over. For dx of CSU, pt is 2 years of age or over. For dx of CRSwNP, pt is 12 years of age or over. For dx of EoE, pt is 1 year of age or over. For dx of COPD with an eosinophilic phenotype, PN, or BP, pt is 18 years of age or over. For dx of AFRS, pt is 6 years of age or over.

Prescriber Restrictions:

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:

b. Pt will continue standard maintenance therapy (e.g., intranasal corticosteroid) in combination with the requested agent OR

F. Pt has a dx of eosinophilic esophagitis (EoE) confirmed by esophageal biopsy OR

G. Pt has a dx of prurigo nodularis (PN) OR

H. Pt has a dx of chronic obstructive pulmonary disease (COPD) with an eosinophilic phenotype AND BOTH of:

i. Pt is currently being treated with AND will continue COPD control therapy (e.g., ICS, LABA, LAMA) in combination with the requested agent AND

ii. Pt 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

I. Pt has a dx of chronic spontaneous urticaria (CSU) AND BOTH of:

i. Pt has had over 6 weeks of hives and itching AND

ii. ONE of:

a. Pt has tried and had an inadequate response to a maximum tolerable H1 antihistamine therapy OR

b. Pt has an intolerance, hypersensitivity, or an FDA labeled contraindication to a maximum tolerable H1 antihistamine therapy

Criteria for renewal approval require ALL of:

1. Pt has been previously approved for the requested agent through the plan's Prior Authorization criteria AND

2. ONE of:

A. Pt has a dx of allergic fungal rhinosinusitis (AFRS) OR

B. Pt has a dx of moderate-to-severe atopic dermatitis AND the following:

i. Pt will NOT be using the requested agent in combination with another biologic agent or a JAK inhibitor for the requested indication OR

C. Pt has a dx of moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid dependent asthma AND BOTH of:

i. Pt 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. Pt 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

D. Pt has a dx of bullous pemphigoid (BP) OR

E. Pt has a dx of chronic rhinosinusitis with nasal polyposis (CRSwNP) AND the following:

i. Pt will continue standard maintenance therapy (e.g., intranasal corticosteroid) in combination with the requested agent OR

F. Pt has a dx of eosinophilic esophagitis (EoE) OR

G. Pt has a dx of prurigo nodularis (PN) OR

H. Pt has a dx of chronic obstructive pulmonary disease (COPD) with an eosinophilic phenotype AND BOTH of:

i. Pt is currently being treated with AND will continue COPD control therapy (e.g., ICS, LABA, LAMA) in combination with the requested agent AND

ii. Pt 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

I. Pt has a dx of chronic spontaneous urticaria (CSU) AND

3. Pt has had clinical benefit with the requested agent

Prior Authorization Group Description:
Emgality PA
Drug Name(s)
Emgality
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Emsam PA
Drug Name(s)
Emsam
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Epidiolex PA
Drug Name(s)
Epidiolex
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Erythropoietin Stimulating Agents PA – Aranesp
Drug Name(s)
Aranesp Albumin Free
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 months for chemotherapy, 12 months for other indications
Other Criteria:

Prior Authorization Group Description:
Erythropoietin Stimulating Agents PA - Epogen/Procrit
Drug Name(s)
Procrit
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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.

Prior Authorization Group Description:
Erythropoietin Stimulating Agents PA – Retacrit
Drug Name(s)
Retacrit
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:

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

Prior Authorization Group Description:
Eysuvis PA
Drug Name(s)
Eysuvis
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 1 month
Other Criteria:

Prior Authorization Group Description:
Fasenra PA
Drug Name(s)
Fasenra
Fasenra Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 OR
    C. Patient has a diagnosis of hypereosinophilic syndrome (HES) without an identifiable non-hematologic secondary cause 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
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. For diagnosis of hypereosinophilic syndrome (HES) without an identifiable non-hematologic secondary cause, patient is 12 years of age or over.
Prescriber Restrictions:
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:
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 OR
    C. Patient has a diagnosis of hypereosinophilic syndrome (HES) without an identifiable non-hematologic secondary cause 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
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

Prior Authorization Group Description:
Fentanyl Oral PA - Fentanyl lozenge
Drug Name(s)
Fentanyl Citrate Oral Transmucosal
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a documented diagnosis (i.e., medical records) of chronic cancer pain due to an active malignancy AND BOTH of the following:
        i. Prescriber has provided the patient's type of cancer AND
        ii. There is evidence of a claim that the patient is currently being treated with a long-acting opioid with the requested agent within the past 90 days OR
    b. Patient has a diagnosis that is supported in CMS approved compendia for the requested agent AND
2. Patient will NOT be using the requested agent in combination with any other oral fentanyl agent
Age Restriction:
Patient is 16 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Fintepla PA
Drug Name(s)
Fintepla
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Flucytosine PA
Drug Name(s)
Flucytosine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Focalin PA
Drug Name(s)
Dexmethylphenidate Hcl (Focalin)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Gammagard/Gammaked/Gamunex-C PA
Drug Name(s)
Gammagard Liquid Erc
Gammagard Liquid
Gamunex-C
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:

Prescriber Restrictions:

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., Avonex, Betaseron, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Kesimpta, Plegridy, Vumerity) 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.

Prior Authorization Group Description:
Gauze Pads PA
Drug Name(s)
Gauze Pads
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Growth Hormone PA – Omnitrope
Drug Name(s)
Omnitrope
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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)

Prior Authorization Group Description:
HAE PA – Haegarda
Drug Name(s)
Haegarda
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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 Restrictions:
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

Prior Authorization Group Description:
HAE PA – Icatibant
Drug Name(s)
Icatibant Acetate
Sajazir
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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 Restrictions:
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

Prior Authorization Group Description:
High Risk Medication PA - All Starts
Drug Name(s)
Cyproheptadine Hcl
Dicyclomine Hcl
Diphenoxylate/Atropine
Hydroxyzine Hcl
Scopolamine
Trihexyphenidyl Hcl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Imiquimod PA
Drug Name(s)
Imiquimod Cream 5%
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Inbrija PA
Drug Name(s)
Inbrija
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:

Ingrezza PA

Drug Name(s)

Ingrezza

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

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:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Injectable Oncology PA
Drug Name(s)
Firmagon
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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. 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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Insulin Pen Needle PA
Drug Name(s)
Insulin Pen Needle
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Insulin Syringe_Needle PA
Drug Name(s)
Insulin Syringe/Needle
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Iron Chelating Agents PA – Exjade
Drug Name(s)
Deferasirox (Exjade)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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 Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Iron Chelating Agents PA – Jadenu
Drug Name(s)
Deferasirox (Jadenu)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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 Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Isotretinoin PA
Drug Name(s)
Accutane
Amnesteem
Claravis
Isotretinoin
Zenatane
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal
Other Criteria:

Prior Authorization Group Description:
Ivermectin Tablet PA
Drug Name(s)
Ivermectin Tablet
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 4 months
Other Criteria:

Prior Authorization Group Description:
Jubbonti PA
Drug Name(s)
Jubbonti
Indications:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Jynarque PA
Drug Name(s)
Tolvaptan (Jynarque)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Kalydeco PA
Drug Name(s)
Kalydeco
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 Restrictions:
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:

Prior Authorization Group Description:
Kerendia PA
Drug Name(s)
Kerendia
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Leuprolide PA
Drug Name(s)
Eligard
Leuprolide Acetate
Lupron Depot
Lupron Depot-Ped
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
L-glutamine PA
Drug Name(s)
L-glutamine
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Lidocaine Topical PA - Lidocaine Ointment
Drug Name(s)
Lidocaine Ointment
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Lidocaine Topical PA - Lidocaine Patch
Drug Name(s)
Lidocaine Patch
Lidocan
Tridacaine Patch
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Lidocaine Topical PA - Lidocaine Solution
Drug Name(s)
Lidocaine Solution
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Lidocaine Topical PA - Lidocaine/prilocaine Cream
Drug Name(s)
Lidocaine/Prilocaine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Linezolid PA
Drug Name(s)
Linezolid
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Lumryz PA
Drug Name(s)
Lumryz
Lumryz Starter Pack
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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 Restrictions:
Coverage Duration:

Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Mavyret PA
Drug Name(s)
Mavyret
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Memantine ER PA
Drug Name(s)
Memantine Hcl Er
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Memantine PA
Drug Name(s)
Memantine Hcl Titration Pak
Memantine Hcl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Methylin PA
Drug Name(s)
Methylphenidate Hcl (Methylin)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Methylphenidate ER Tablet PA
Drug Name(s)
Methylphenidate Hcl Er Tablet
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Miebo PA
Drug Name(s)
Miebo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Mifepristone PA
Drug Name(s)
Mifepristone
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Migranal PA
Drug Name(s)
Dihydroergotamine Mesylate Spray
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 a triptan agent OR
    C. Patient has an FDA labeled contraindication to a triptan agent 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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Modafinil PA
Drug Name(s)
Modafinil
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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 Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Mounjaro PA
Drug Name(s)
Mounjaro
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Avonex
Drug Name(s)
Avonex
Avonex Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Betaseron
Drug Name(s)
Betaseron
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA - Dimethyl Fumarate
Drug Name(s)
Dimethyl Fumarate
Dimethyl Fumarate Starterpack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Fingolimod
Drug Name(s)
Fingolimod Hcl
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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 will perform an electrocardiogram 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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Glatiramer
Drug Name(s)
Glatiramer Acetate
Glatopa
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Kesimpta
Drug Name(s)
Kesimpta
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Plegridy
Drug Name(s)
Plegridy
Plegridy Starter Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Vumerity
Drug Name(s)
Vumerity
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Nexletol PA
Drug Name(s)
Nexletol
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has 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. Pretreatment LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) OR
        iii. Patient has clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, corneal arcus, tuberous xanthoma, or xanthelasma) OR
        iv. Patient has “definite” or “possible” familial hypercholesterolemia as defined by the Simon Broome criteria OR
        v. Patient has a Dutch Lipid Clinic Network criteria score of greater than 5 OR
    B. Patient is at increased risk of major adverse cardiovascular events (MACE) [coronary heart disease death, myocardial infarction (MI), stroke, coronary revascularization] AND the requested agent will be used to reduce the risk of these events OR
    C. Patient has a diagnosis of hypercholesterolemia [not associated with HeFH or increased risk of MACE] AND
2. ONE of the following:
    A. Patient is on statin therapy OR
    B. Patient has an intolerance to TWO different statins OR
    C. Patient has an FDA labeled contraindication to a statin
Age Restriction:
Prescriber Restrictions:
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 heterozygous familial hypercholesterolemia (HeFH) OR
    B. Patient is at increased risk of major adverse cardiovascular events (MACE) [coronary heart disease death, myocardial infarction (MI), stroke, coronary revascularization] AND the requested agent will be used to reduce the risk of these events OR

C. Patient has a diagnosis of hypercholesterolemia [not associated with HeFH or increased risk of MACE] AND

3. ONE of the following:
    A. Patient is on statin therapy OR
    B. Patient has an intolerance to TWO different statins OR
    C. Patient has an FDA labeled contraindication to a statin AND
4. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Nexlizet PA
Drug Name(s)
Nexlizet
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has 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. Pretreatment LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) OR
        iii. Patient has clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, corneal arcus, tuberous xanthoma, or xanthelasma) OR
        iv. Patient has “definite” or “possible” familial hypercholesterolemia as defined by the Simon Broome criteria OR
        v. Patient has a Dutch Lipid Clinic Network criteria score of greater than 5 OR
    B. Patient is at increased risk of major adverse cardiovascular events (MACE) [coronary heart disease death, myocardial infarction (MI), stroke, coronary revascularization] AND the requested agent will be used to reduce the risk of these events OR
    C. Patient has a diagnosis of hypercholesterolemia [not associated with HeFH or increased risk of MACE] AND
2. ONE of the following:
    A. Patient is on statin therapy OR
    B. Patient has an intolerance to TWO different statins OR
    C. Patient has an FDA labeled contraindication to a statin
Age Restriction:
Prescriber Restrictions:
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 heterozygous familial hypercholesterolemia (HeFH) OR
    B. Patient is at increased risk of major adverse cardiovascular events (MACE) [coronary heart disease death, myocardial infarction (MI), stroke, coronary revascularization] AND the requested agent will be used to reduce the risk of these events OR

C. Patient has a diagnosis of hypercholesterolemia [not associated with HeFH or increased risk of MACE] AND

3. ONE of the following:
    A. Patient is on statin therapy OR
    B. Patient has an intolerance to TWO different statins OR
    C. Patient has an FDA labeled contraindication to a statin AND
4. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Nuedexta PA
Drug Name(s)
Nuedexta
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Nuplazid PA
Drug Name(s)
Nuplazid
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Nurtec PA
Drug Name(s)
Nurtec
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Ofev PA
Drug Name(s)
Nintedanib
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Omnipod PA
Drug Name(s)
Omnipod Kit
Omnipod Pods
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of diabetes mellitus AND
2. Patient is on an insulin regimen of 3 or more injections per day AND
3. ONE of the following:
    A. Patient is testing glucose levels 4 or more times per day OR
    B. Patient is using a continuous glucose monitor (CGM)

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 diabetes mellitus AND
3. Patient has had clinical benefit with the requested agent (e.g., stable or improved glycemic control)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Ophthalmic Immunomodulators PA – Xiidra
Drug Name(s)
Xiidra
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Opioids ER PA - Fentanyl Patch
Drug Name(s)
Fentanyl Patch
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Opioids ER PA – Morphine
Drug Name(s)
Morphine Sulfate Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Opioids ER PA – Tramadol
Drug Name(s)
Tramadol Hcl Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Orkambi PA
Drug Name(s)
Orkambi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 Restrictions:
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:

Prior Authorization Group Description:
Osenvelt PA
Drug Name(s)
Osenvelt
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Otezla PA
Drug Name(s)
Otezla
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 plaque psoriasis 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 active psoriatic arthritis OR
    C. 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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Formulary conventional agent required for diagnosis of plaque psoriasis

Formulary conventional agents for plaque psoriasis include cyclosporine, methotrexate, tazarotene, topical calcitriol, or topical corticosteroids

NO prerequisites are required for diagnoses of active psoriatic arthritis or oral ulcers associated with Behcet's disease (BD)

Prior Authorization Group Description:
Otezla Xr PA
Drug Name(s)
Otezla Xr
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 plaque psoriasis 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 active psoriatic arthritis OR
    C. 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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Formulary conventional agent required for diagnosis of plaque psoriasis

Formulary conventional agents for plaque psoriasis include cyclosporine, methotrexate, tazarotene, topical calcitriol, or topical corticosteroids

NO prerequisites are required for diagnoses of active psoriatic arthritis or oral ulcers associated with Behcet's disease (BD)

Prior Authorization Group Description:
Ozempic PA
Drug Name(s)
Ozempic Inj
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Panretin PA
Drug Name(s)
Panretin
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Pegylated Interferon PA
Drug Name(s)
Pegasys
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Pirfenidone PA
Drug Name(s)
Pirfenidone
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Posaconazole PA
Drug Name(s)
Posaconazole
Posaconazole Dr
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:

Promacta PA

Drug Name(s)

Eltrombopag

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

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:

Prescriber Restrictions:

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

Prior Authorization Group Description:
Pulmonary Hypertension PA – Adempas
Drug Name(s)
Adempas
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Pulmonary Hypertension PA – Ambrisentan
Drug Name(s)
Ambrisentan
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Pulmonary Hypertension PA – Bosentan
Drug Name(s)
Bosentan
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:

Prescriber Restrictions:

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

Prior Authorization Group Description:
Pulmonary Hypertension PA – Orenitram
Drug Name(s)
Orenitram
Orenitram Titration Kit
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:

Prescriber Restrictions:

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

Prior Authorization Group Description:
Pulmonary Hypertension PA – Sildenafil
Drug Name(s)
Sildenafil Citrate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:

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

Prior Authorization Group Description:
Pulmonary Hypertension PA – Tadalafil
Drug Name(s)
Tadalafil Tablet 20Mg
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:

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

Prior Authorization Group Description:
Pulmonary Hypertension PA – Ventavis
Drug Name(s)
Ventavis
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:

Prescriber Restrictions:

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

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

Prior Authorization Group Description:
Pulmonary Hypertension PA – Winrevair
Drug Name(s)
Winrevair
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Pyrimethamine PA
Drug Name(s)
Pyrimethamine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Pyrukynd PA
Drug Name(s)
Pyrukynd
Pyrukynd Taper Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Quinine PA
Drug Name(s)
Quinine Sulfate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be 7 days for malaria,12 months for all other diagnoses
Other Criteria:

Prior Authorization Group Description:
Repatha PA
Drug Name(s)
Repatha
Repatha Sureclick
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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
    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 400 mg/dL or greater (10 mmol/L or greater) AND ONE of the following:
            a. Cutaneous or tendon xanthomas before 20 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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

C. An increased risk of major adverse cardiovascular (CV) events [CV death, myocardial infarction (MI), stroke, unstable angina requiring hospitalization, or coronary revascularization] AND the requested agent will be used to reduce the risk of these events OR

D. A diagnosis of hypercholesterolemia [not associated with HeFH, HoFH, or increased risk of major adverse cardiovascular (CV) events] 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

Prior Authorization Group Description:
Revcovi PA
Drug Name(s)
Revcovi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Rezdiffra PA
Drug Name(s)
Rezdiffra
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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 ONE of the following (prior to therapy with the requested agent):
    A. A liver biopsy OR
    B. ONE of the following:
        i. Vibration-controlled transient elastography (VCTE, e.g., Fibroscan) OR
        ii. Enhanced liver fibrosis (ELF) OR
        iii. 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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Ritalin PA
Drug Name(s)
Methylphenidate Hcl (Ritalin)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:

Roflumilast PA

Drug Name(s)

Roflumilast

Indications:

All FDA-Approved Indications.

Off-Label Uses:

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:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Rybelsus PA
Drug Name(s)
Ozempic Tab
Rybelsus
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Sapropterin PA
Drug Name(s)
Sapropterin Dihydrochloride
Zelvysia
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Self - Administered Oncology PA
Drug Name(s)
Abiraterone Acetate
Abirtega
Akeega
Alecensa
Alunbrig
Augtyro
Avmapki Fakzynja Co-Pack
Ayvakit
Balversa
Besremi
Bexarotene Capsules
Bosulif
Bosutinib
Braftovi
Brukinsa
Cabometyx
Calquence
Caprelsa
Cavhanza
Cometriq
Copiktra
Cotellic
Danziten
Dasatinib
Daurismo
Ensacove
Erivedge
Erleada
Erlotinib Hcl
Everolimus
Fotivda
Fruzaqla
Gavreto
Gefitinib
Gilotrif
Gomekli
Hernexeos
Hyrnuo
Ibrance
Ibtrozi

Iclusig
Idhifa
Imatinib Mesylate
Imbruvica
Imkeldi
Inluriyo
Inlyta
Inqovi
Inrebic
Itovebi
Iwilfin
Jakafi
Jaypirca
Kisqali
Kisqali Femara
Komzifti
Koselugo
Krazati
Lapatinib Ditosylate
Lazcluze
Lenalidomide
Lenvima
Lifyorli
Lonsurf
Lorbrena
Lumakras
Lynparza
Lytgobi
Matulane
Mekinist
Mektovi
Modeyso
Nerlynx
Nilotinib
Ninlaro
Nubeqa
Odomzo
Ogsiveo
Ojemda
Ojjaara
Onureg
Orgovyx
Orserdu

Pazopanib Hcl
Pemazyre
Piqray
Pomalidomide
Qinlock
Retevmo
Revuforj
Rezlidhia
Romvimza
Rozlytrek
Rubraca
Rydapt
Scemblix
Sorafenib
Stivarga
Sunitinib Malate
Tabrecta
Tafinlar
Tagrisso
Talzenna
Tepmetko
Thalomid
Tibsovo
Torpenz
Tretinoin Capsule
Truqap
Tukysa
Turalio
Vanflyta
Venclexta
Venclexta Starting Pack
Veppanu
Verzenio
Vitrakvi
Vizimpro
Vonjo
Voranigo
Welireg
Xalkori
Xospata
Xpovio
Xtandi

Yulithira
Zejula
Zelboraf
Zolinza
Zydelig
Zykadia

Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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 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

Prior Authorization Group Description:
Signifor PA
Drug Name(s)
Signifor
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Sivextro PA
Drug Name(s)
Sivextro
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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 Restrictions:
Coverage Duration:
Approval will be 6 days for ABSSSI or 30 days for all other indications

Other Criteria:

Prior Authorization Group Description:
Sodium Oxybate PA
Drug Name(s)
Sodium Oxybate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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 Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Somatostatin Analogs PA – Octreotide
Drug Name(s)
Octreotide Acetate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Somatostatin Analogs PA – Somavert
Drug Name(s)
Somavert
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Stoboclo PA
Drug Name(s)
Stoboclo
Indications:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Substrate Reduction Therapy PA – Miglustat
Drug Name(s)
Miglustat
Yargesa
Indications:
All FDA-Approved Indications, Some Medically-Accepted Indications.
Off-Label Uses:
Niemann-Pick disease type C (NPC)
Exclusion Criteria:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Tasimelteon Capsule PA
Drug Name(s)
Tasimelteon
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 Restrictions:
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:

Prior Authorization Group Description:
Teriparatide PA
Drug Name(s)
Bonsity
Teriparatide
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:

Prescriber Restrictions:

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)

Prior Authorization Group Description:
Tetrabenazine PA
Drug Name(s)
Tetrabenazine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Tobramycin neb PA
Drug Name(s)
Tobramycin Neb
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Topical Diclofenac 3% Gel PA
Drug Name(s)
Diclofenac Sodium Gel 3%
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 3 months
Other Criteria:

Prior Authorization Group Description:
Topical NSAID PA – Pennsaid
Drug Name(s)
Diclofenac Sodium (Pennsaid)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
3 months for acute pain, 12 months for all other diagnoses
Other Criteria:

Prior Authorization Group Description:
Topical Retinoids PA – Tazarotene
Drug Name(s)
Tazarotene
Trilitas
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Topical Retinoids PA – Tretinoin
Drug Name(s)
Tretinoin Cream, Gel
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Trelstar PA
Drug Name(s)
Trelstar Mixject
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Trientine PA
Drug Name(s)
Trientine Hcl
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Trikafta PA
Drug Name(s)
Trikafta
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 at least ONE variant in the CFTR gene that is either responsive based on clinical and/or in vitro data or results in production of CFTR protein, 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 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 Restrictions:
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:

Prior Authorization Group Description:

Trulicity PA

Drug Name(s)

Trulicity

Indications:

All FDA-Approved Indications.

Off-Label Uses:

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:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:

Tymlos PA

Drug Name(s)

Tymlos

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Urea Cycle Disorders PA - Sodium Phenylbutyrate
Drug Name(s)
Sodium Phenylbutyrate
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Valchlor PA
Drug Name(s)
Valchlor
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
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:

Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Veozah PA
Drug Name(s)
Veozah
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Viberzi PA
Drug Name(s)
Viberzi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Voriconazole PA
Drug Name(s)
Voriconazole
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:
Vosevi PA
Drug Name(s)
Vosevi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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:

Prior Authorization Group Description:
Vowst PA
Drug Name(s)
Vowst
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 Restrictions:
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:

Prior Authorization Group Description:
Wyost PA
Drug Name(s)
Wyost
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
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

Prior Authorization Group Description:

Xdemvy PA

Drug Name(s)

Xdemvy

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

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:

Prescriber Restrictions:

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:

Prior Authorization Group Description:
Xermelo PA
Drug Name(s)
Xermelo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Xifaxan 550 MG Tablet PA
Drug Name(s)
Xifaxan 550Mg
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Xolair PA
Drug Name(s)
Xolair
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 Restrictions:

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

Prior Authorization Group Description:
Zokinvy PA
Drug Name(s)
Zokinvy
Indications:
All FDA-Approved Indications.
Off-Label Uses:
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. Patient has a diagnosis of Hutchinson-Gilford progeria syndrome (HGPS) AND
        ii. Genetic testing has confirmed a pathogenic variant in the LMNA gene that results in production of progerin OR
    B. Patient has a diagnosis of processing-deficient progeroid laminopathy AND ONE of the following:
        i. Genetic testing has confirmed heterozygous LMNA mutation with progerin-like protein accumulation OR
        ii. Genetic testing has confirmed homozygous or compound heterozygous ZMPSTE24 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 ONE of the following:
    A. Hutchinson-Gilford progeria syndrome (HGPS) OR
    B. Processing-deficient progeroid laminopathies with either: heterozygous LMNA mutation with progerin-like protein accumulation OR homozygous or compound heterozygous ZMPSTE24 mutations AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist, geneticist) 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:

Prior Authorization Group Description:
Ztalmy PA
Drug Name(s)
Ztalmy
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
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 Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2027, and from time to time during the year.

This document includes EmblemHealth Medicare PDP partial formulary as of September 1, 2026. For a complete, updated formulary, please visit our Web site at http://www.emblemhealth.com/medicare or call the Customer Service number below:

For alternative formats or language, please call Customer Service toll free at: EmblemHealth Medicare PDP: 1-833-998-5351, (TTY users should call **711**), 24 hours a day 7 days a week, or visit **emblemhealth.com/medicare**.

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