



2027 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.

2027 PRIOR AUTHORIZATION CRITERIA

TABLE OF CONTENTS

A

Abiraterone Acetate	354
Abirtega	354
Accutane	152
Acitretin	10
Actimmune	11
Acyclovir Oint	12
Adempas	210
Aimovig	13
Akeega	229
Alcohol Swabs	14
Alecensa	230
Alosetron Hcl	15
Alprazolam	68
Alunbrig	231
Ambrisentan	211
Amnesteem	152
Aranesp Albumin Free	123
Arcalyst	58
Arikayce	59
Aripiprazole Odt	19
Aripiprazole Sol	20
Aripiprazole Tab	21
Armodafinil	60
Asenapine Maleate Sl	22
Atovaquone	63
Augtyro	232
Austedo	64
Austedo Xr	64
Austedo Xr Patient Titration Kit	64
Avmapki Fakzynja Co-Pack	233
Avonex	177
Avonex Pen	177
Ayvakit	234

B

Balversa	235
Belsomra	65
Benlysta	67
Benzotropine Mesylate	139
Besremi	236
Betaseron	178
Bexarotene Cap	324
Bexarotene Gel	76

Bildyos.....	77
Bilprevda.....	78
Bonsity.....	363
Bosulif Cap.....	237
Bosulif Tab.....	238
Bosutinib Tab.....	238
Braftovi.....	239
Brukinsa.....	240
Budesonide Dr (Entocort).....	94
Budesonide Er (Uceris).....	95
Bysanti.....	23

C

Cabometyx.....	241
Calquence.....	242
Caprelsa.....	243
Carglumic Acid.....	96
Cavhanza.....	244
Cayston.....	97
Chlorpromazine Sol.....	24
Chlorpromazine Tab.....	25
Cinacalcet Hcl.....	98
Claravis.....	152
Clobazam.....	69
Clorazepate Dipotassium.....	70
Clozapine.....	27
Clozapine Odt.....	26
Cobenfy.....	99
Cobenfy Starter Pack.....	99
Cometriq.....	245
Copiktra.....	246
Cosentyx.....	80
Cosentyx Sensoready Pen.....	80
Cosentyx Unoready.....	80
Cotellic.....	247
Cresemba.....	106
Ctexli.....	107
Cystagon.....	109
Cystaran.....	108

D

Dalfampridine Er.....	110
Danazol.....	17
Danziten.....	248
Dasatinib.....	316
Daurismo.....	249
Dayvigo.....	111
Deferasirox (Exjade).....	150
Deferasirox (Jadenu).....	151
Dexmethylphenidate Hcl (Focalin).....	131
Diacomit.....	112
Diazepam.....	71
Diazepam Intensol.....	71
Diclofenac Sodium (Pennsaid).....	369
Diclofenac Sodium Gel 3%.....	368

Dicyclomine Hcl	140
Dihydroergotamine Mesylate	174
Dimethyl Fumarate.....	179
Dimethyl Fumarate Starterpack.....	179
Diphenoxylate/Atropine.....	142
Doptelet Cap	113
Doptelet Tab	114
Droxidopa	116
Dupixent.....	117

E

Eligard	118
Eltrombopag Olamine	119
Emgality.....	120
Emsam.....	121
Enbrel	81
Enbrel Mini.....	81
Enbrel Sureclick.....	81
Ensacove.....	250
Entyvio Pen.....	82
Epidiolex.....	122
Erivedge.....	251
Erleada	252
Erlotinib Hcl.....	323
Eucrisa.....	61
Everolimus Tab	227
Everolimus Tab (for Oral Susp)	228
Eysuvis	125

F

Fanapt.....	28
Fasenra.....	126
Fasenra Pen.....	126
Fentanyl.....	196
Filspari	128
Fingolimod Hcl	180
Fintepla	129
Firmagon	147
Flucytosine	130
Fluphenazine Decanoate.....	30
Fluphenazine Hcl (Elixer).....	29
Fluphenazine Hcl (Inj)	30
Fluphenazine Hcl (Sol).....	31
Fluphenazine Hcl (Tab)	32
Fotivda	253
Fruzaqla.....	254
Fulphila	100
Fynetra.....	101

G

Gammagard Liquid	132
Gammagard Liquid Erc	133
Gamunex-C	134
Gauze Pads	135
Gavreto.....	255

Gefitinib	271
Gilotrif	256
Glatiramer Acetate.....	181
Glatopa	181
Gomekli.....	258

H

Hadlima.....	83
Hadlima Pushtouch	83
Haegarda	137
Haloperidol Decanoate Inj.....	33
Haloperidol Lactate Inj	33
Haloperidol Sol.....	34
Haloperidol Tab	35
Hernexeos.....	259
Hydroxyzine Hcl.....	141
Hyrnuo	260

I

Ibrance	261
Ibtrozi	262
Icatibant Acetate.....	138
Iclusig.....	263
Idhifa.....	264
Imatinib Mesylate.....	257
Imbruvica.....	265
Imiquimod Cream 5%	145
Imkeldi	266
Inbrija	146
Inluriyo	267
Inlyta	268
Inqovi.....	269
Inrebic	270
Insulin Pen Needle	148
Insulin Syringe/Needle.....	149
Isotretinoin	152
Itovebi	272
Ivabradine Hcl.....	105
Ivermectin Tab	153
Iwilfin.....	273

J

Jakafi.....	274
Jaypirca	275

K

Kalydeco.....	155
Kerendia.....	156
Kesimpta	182
Kisqali.....	276
Komzifti	277
Koselugo.....	278
Krazati	279

L

Lapatinib Ditosylate	333
Lazcluze	280
Lenalidomide.....	308
Lenvima	281
Leukine	102
Leuprolide Acetate (Lupron)	164
Leuprolide Acetate (Lutrate Depot).....	165
L-Glutamine	157
Lidocaine Ointment	158
Lidocaine Patch	159
Lidocaine Solution	160
Lidocaine/Prilocaine	161
Lidocan.....	159
Lifyorli	282
Lonsurf.....	283
Lorazepam.....	72
Lorazepam Intensol.....	72
Lorbrenea.....	284
Loxapine	36
Lumakras	285
Lupron Depot (1-Month)	162
Lupron Depot-Ped (1-Month).....	163
Lupron Depot-Ped (3-Month).....	163
Lupron Depot-Ped (6-Month).....	163
Lurasidone Hcl.....	37
Lybalvi.....	38
Lynparza.....	286
Lytgobi	287

M

Matulane.....	288
Mavyret.....	166
Mekinist.....	289
Mektovi	290
Memantine Hcl.....	168
Memantine Hcl Er.....	167
Memantine Hcl Titration Pak.....	168
Methylphenidate Hcl (Methylin)	169
Methylphenidate Hcl (Ritalin)	222
Methylphenidate Hcl Er Tablet	170
Metyrosine	171
Miebo	172
Mifepristone	173
Modafinil	175
Modeyso	291
Molindone Hcl.....	39
Morphine Sulfate Er	198
Mounjaro.....	176

N

Nayzilam.....	73
Nerlynx.....	292
Nexletol.....	185

Nexlizet	186
Nilotinib.....	325
Ninlaro	294
Nintedanib Esylate.....	187
Nitisinone.....	188
Nivestym	103
Nubeqa.....	295
Nucala.....	189
Nuedexta	191
Nuplazid	192
Nurtec.....	193

O

Octreotide Acetate	359
Odomzo.....	296
Ofev.....	187
Ogsiveo.....	297
Ojemda.....	298
Ojjaara	299
Olanzapine Inj.....	40
Olanzapine Odt.....	41
Olanzapine Tab.....	42
Omnipod Go	194
Omnipod Kit.....	194
Omnipod Pods	194
Omnitrope	136
Onureg.....	300
Opipza.....	43
Orenitram	212
Orenitram Titration Kit	212
Orgovyx.....	301
Orserdu	302
Otezla	202
Otezla Xr.....	203
Ozempic Inj.....	204
Ozempic Tab.....	205

P

Paliperidone Er	44
Panretin	206
Pazopanib Hcl	342
Pegasys.....	207
Pemazyre	303
Perphenazine	45
Pimozide.....	46
Piqray.....	304
Pirfenidone.....	208
Plegridy.....	183
Plegridy Starter Pack.....	183
Pomalidomide.....	305
Pomalyst.....	305
Posaconazole Dr.....	209
Prolastin-C.....	16
Primethamine.....	215
Pyrukynd.....	216

Pyrukynd Taper Pack	216
Pyzchiva.....	84

Q

Qinlock	306
Quetiapine Fumarate	47
Quetiapine Fumarate Er	48
Quinine Sulfate	217

R

Repatha	218
Repatha Sureclick.....	218
Retacrit.....	124
Retevmo.....	307
Revcovi.....	219
Revuforj	309
Rexulti	49
Rezdiffra.....	220
Rezlidhia.....	310
Rezurock	221
Rinvoq Lq.....	85
Rinvoq Tab	86
Risperidone Odt.....	50
Risperidone Sol	51
Roflumilast.....	223
Romvimza.....	311
Rozlytrek.....	312
Rubraca.....	313
Rufinamide.....	224
Rybelsus	225
Rydapt	314

S

Sapropterin Dihydrochloride.....	226
Scemblix	315
Scopolamine	143
Secuado.....	52
Signifor.....	355
Sildenafil Citrate	213
Simlandi.....	87
Sirturo	356
Skyrizi.....	88
Skyrizi Pen.....	88
Sodium Oxybate.....	357
Sodium Phenylbutyrate.....	377
Somavert	360
Sorafenib	293
Stivarga	317
Sunitinib Malate.....	318
Sympazan.....	74

T

Tabrecta.....	319
Tacrolimus.....	62
Tadalafil Tablet 2.5Mg; 5Mg.....	66

Tafinlar.....	320
Tagrisso	321
Talzenna.....	322
Tarpeyo.....	361
Tasimelteon	362
Tazarotene	370
Tepmetko.....	326
Teriparatide.....	363
Testosterone Enanthate	18
Testosterone Gel.....	364
Testosterone Pump	364
Tetrabenazine.....	365
Thalomid	327
Thioridazine Hcl	53
Thiothixene.....	54
Tibsovo	328
Tobi Podhaler.....	366
Tobramycin Neb	367
Tolvaptan (Jynarque)	154
Torpenz.....	227
Tramadol Hcl Er.....	200
Trelstar Mixject.....	372
Tremfya	89
Tretinoin (Topical).....	371
Tretinoin Cap	329
Tridacaine.....	159
Trientine Hcl.....	373
Trifluoperazine Hcl.....	55
Trihexyphenidyl Hcl.....	144
Trikafta	374
Trulicity	375
Truqap.....	330
Tukysa	331
Turalio.....	332
Tyenne.....	90
Tymlos.....	376

V

Valchlor.....	378
Valtoco.....	75
Vanflyta.....	334
Velsipity.....	91
Venclexta.....	335
Veozah.....	379
Veppanu.....	336
Versacloz.....	56
Verzenio.....	337
Vitrakvi	338
Vizimpro.....	339
Vonjo	340
Voranigo.....	341
Voriconazole.....	380
Vosevi	381
Vowst.....	382
Vumerity.....	184

W

Wegovy Inj.....	383
Wegovy Tab	384
Welireg.....	343
Winrevair	214

X

Xalkori.....	344
Xdemvy	385
Xermelo.....	386
Xifaxan 200Mg.....	387
Xifaxan 550Mg.....	388
Xiidra.....	195
Xolair.....	389
Xospata.....	345
Xpovio.....	346
Xtandi.....	347

Y

Yesintek	92
Yonsa.....	348
Yulithira.....	227

Z

Zarxio.....	104
Zejula	349
Zelboraf.....	350
Zenatane.....	152
Ziprasidone Mesylate	57
Zokinvy	392
Zolinza.....	351
Ztalmy.....	393
Zydelig.....	352
Zykadia.....	353
Zymfentra	93

Prior Authorization Group Description:

Acitretin PA

Drug Name(s)

Acitretin

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 BOTH of the following:

1. ONE of the following:

A. BOTH of the following:

i. Patient has a diagnosis of severe psoriasis AND

ii. ONE of the following:

1. Patient has tried and had an inadequate response to BOTH methotrexate and cyclosporine OR

2. Patient has an intolerance or hypersensitivity to BOTH methotrexate and cyclosporine OR

3. Patient has an FDA labeled contraindication to BOTH methotrexate and cyclosporine OR

B. Patient has 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

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 psoriasis OR

B. Patient has 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. 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., dermatologist) 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Acyclovir Ointment PA

Drug Name(s)

Acyclovir Oint

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:

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Aimovig PA

Drug Name(s)

Aimovig

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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 severe diarrhea-predominant irritable bowel syndrome (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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:

Pending CMS Review

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Aripiprazole ODT

Drug Name(s)

Aripiprazole Odt

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Aripiprazole Solution

Drug Name(s)

Aripiprazole Sol

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Aripiprazole Tablet

Drug Name(s)

Aripiprazole Tab

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Asenapine Tablet

Drug Name(s)

Asenapine Maleate SI

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Bysanti

Drug Name(s)

Bysanti

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Chlorpromazine Solution

Drug Name(s)

Chlorpromazine Sol

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Chlorpromazine Tablet

Drug Name(s)

Chlorpromazine Tab

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Clozapine ODT

Drug Name(s)

Clozapine Odt

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Clozapine Tablet

Drug Name(s)

Clozapine

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Fanapt

Drug Name(s)

Fanapt

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Fluphenazine Elixir

Drug Name(s)

Fluphenazine Hcl (Elixer)

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Fluphenazine Inj

Drug Name(s)

Fluphenazine Decanoate

Fluphenazine Hcl (Inj)

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Fluphenazine Solution

Drug Name(s)

Fluphenazine Hcl (Sol)

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Fluphenazine Tablet

Drug Name(s)

Fluphenazine Hcl (Tab)

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Haloperidol Inj

Drug Name(s)

Haloperidol Decanoate Inj

Haloperidol Lactate Inj

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Haloperidol Solution

Drug Name(s)

Haloperidol Sol

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Haloperidol Tablet

Drug Name(s)

Haloperidol Tab

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Loxapine

Drug Name(s)

Loxapine

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Lurasidone

Drug Name(s)

Lurasidone Hcl

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Lybalvi

Drug Name(s)

Lybalvi

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Molindone

Drug Name(s)

Molindone Hcl

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Olanzapine Inj

Drug Name(s)

Olanzapine Inj

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Olanzapine ODT

Drug Name(s)

Olanzapine Odt

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Olanzapine Tablet

Drug Name(s)

Olanzapine Tab

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Opipza

Drug Name(s)

Opipza

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Paliperidone Tablet

Drug Name(s)

Paliperidone Er

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Perphenazine

Drug Name(s)

Perphenazine

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Pimozide

Drug Name(s)

Pimozide

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Quetiapine

Drug Name(s)

Quetiapine Fumarate

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Quetiapine ER

Drug Name(s)

Quetiapine Fumarate Er

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Rexulti

Drug Name(s)

Rexulti

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Risperidone ODT

Drug Name(s)

Risperidone Odt

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Risperidone Solution

Drug Name(s)

Risperidone Sol

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Secuado

Drug Name(s)

Secuado

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Thioridazine

Drug Name(s)

Thioridazine Hcl

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Thiothixene

Drug Name(s)

Thiothixene

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Trifluoperazine

Drug Name(s)

Trifluoperazine Hcl

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Antipsychotics PA - Versacloz

Drug Name(s)

Versacloz

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Antipsychotics PA - Ziprasidone Inj

Drug Name(s)

Ziprasidone Mesylate

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

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 (DIRA) 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Arikayce PA

Drug Name(s)

Arikayce

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

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 initial approval require BOTH of the following:

1. ONE of the following:

- A. Patient has a diagnosis of excessive sleepiness associated with narcolepsy as confirmed by a sleep study OR
- B. Patient has a diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA) as confirmed by a sleep study OR
- C. Patient has another 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)

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 excessive sleepiness associated with narcolepsy OR
- B. Patient has a diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA) OR
- C. Patient has another 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 target agent (i.e., modafinil)

Age Restriction:

Patient is 18 years of age or over

Prescriber Restrictions:**Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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 the following:

1. ONE of the following:

A. Patient has a diagnosis of atopic dermatitis AND ONE of the following:

i. Patient has tried and had an inadequate response to a topical corticosteroid or topical corticosteroid combination preparation (e.g., hydrocortisone, triamcinolone) OR

ii. Patient has an intolerance or hypersensitivity to a topical corticosteroid or topical corticosteroid combination preparation OR

iii. Patient has an FDA labeled contraindication to a topical corticosteroid or topical corticosteroid combination preparation 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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:

Pending CMS Review

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:

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Benign Prostatic Hyperplasia PA - Tadalafil

Drug Name(s)

Tadalafil Tablet 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 is using the requested agent for 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:

Benlysta SC PA

Drug Name(s)

Benlysta

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Benzodiazepines PA - Alprazolam

Drug Name(s)

Alprazolam

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:

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 or panic 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:

Benzodiazepines PA - Clobazam

Drug Name(s)

Clobazam

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:

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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:**

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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:**

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:

Benzodiazepines PA - Nayzilam

Drug Name(s)

Nayzilam

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:

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 an FDA labeled indication or 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Benzodiazepines PA - Sympazan

Drug Name(s)

Sympazan

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:

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Benzodiazepines PA - Valtoco

Drug Name(s)

Valtoco

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:

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 an FDA labeled indication or 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:

Pending CMS Review

Prior Authorization Group Description:

Bildyos PA

Drug Name(s)

Bildyos

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:

Pending CMS Review

Prior Authorization Group Description:

Bilprevda PA

Drug Name(s)

Bilprevda

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. 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

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

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:

Pending CMS Review

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:

Pending CMS Review

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:

Pending CMS Review

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:

Pending CMS Review

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:

Pending CMS Review

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

Part B Prerequisite:

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:

Biologic Immunomodulators PA - Rinvoq Tablet

Drug Name(s)

Rinvoq Tab

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Pending CMS Review

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:

Pending CMS Review

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:

Pending CMS Review

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:

Pending CMS Review

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:

Pending CMS Review

Prior Authorization Group Description:

Biologic Immunomodulators PA - Velsipity

Drug Name(s)

Velsipity

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Biologic Immunomodulators PA - Yesintek

Drug Name(s)

Yesintek

Indications:

All FDA-Approved Indications.

Off-Label Uses:**Exclusion Criteria:**

FDA labeled contraindications to the requested agent

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Biologic Immunomodulators PA - Zymfentra

Drug Name(s)

Zymfentra

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Pending CMS Review

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:

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 56 days) being treated with another inhaled antibiotic (e.g., inhaled tobramycin) OR
 - b. Patient is currently (within the past 56 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:

Pending CMS Review

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:

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Colony Stimulating Factors PA - Fylnetra

Drug Name(s)

Fylnetra

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:

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Colony Stimulating Factors PA - Leukine

Drug Name(s)

Leukine

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Colony Stimulating Factors PA - Zarxio

Drug Name(s)

Zarxio

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Corlanor PA

Drug Name(s)

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 a 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Ctexli PA

Drug Name(s)

Ctexli

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 cerebrotendinous xanthomatosis (CTX) as confirmed by ONE of the following:
 - A. Genetic testing confirming variants in the CYP27A1 gene OR
 - B. ALL of the following:
 - i. Elevated plasma cholestanol greater than or equal to 5 to 10 times ULN (upper limit of normal) AND
 - ii. Urine positive for bile alcohols AND
 - iii. Clinical findings consistent for CTX (e.g., xanthomas [present in lungs, tendons, bone or central nervous system], infantile-onset diarrhea, childhood-onset cataract(s), adult-onset progressive neurologic dysfunction [dementia, psychiatric disturbances, pyramidal and/or cerebellar signs, dystonia, atypical parkinsonism, peripheral neuropathy, and seizures])

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 cerebrotendinous xanthomatosis (CTX) 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., endocrinologist, gastroenterologist, 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 clinical benefit with the requested agent

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Diacomit PA

Drug Name(s)

Diacomit

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

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 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 thrombocytopenia (ITP) AND ONE of the following:
 - A. Patient's platelet count is $50 \times 10^9/L$ 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:

Doptelet Tablet 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 $50 \times 10^9/L$ 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 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 $50 \times 10^9/L$ 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 thrombocytopenia (ITP) AND ONE of the following:

- i. Patient's platelet count is $50 \times 10^9/L$ 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

Part B Prerequisite:

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:

Droxidopa PA

Drug Name(s)

Droxidopa

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Dupixent PA

Drug Name(s)

Dupixent

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Eligard PA

Drug Name(s)

Eligard

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Eltrombopag PA

Drug Name(s)

Eltrombopag Olamine

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Emgality PA

Drug Name(s)

Emgality

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Emsam PA

Drug Name(s)

Emsam

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Epidiolex PA

Drug Name(s)

Epidiolex

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

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:

Pending CMS 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:

Pending CMS Review

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:

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

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, Exdensus, 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, Exdensur, Nucala) for the requested indication

Part B Prerequisite:

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:

Filspari PA

Drug Name(s)

Filspari

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Fintepla PA

Drug Name(s)

Fintepla

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Gammagard PA

Drug Name(s)

Gammagard Liquid

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Gammgd ERC PA

Drug Name(s)

Gammagard Liquid Erc

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Gamunex-C PA

Drug Name(s)

Gamunex-C

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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:

Pending CMS Review

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:

Pending CMS Review

Prior Authorization Group Description:

HAE PA - Icatibant

Drug Name(s)

Icatibant Acetate

Indications:

All FDA-Approved Indications.

Off-Label Uses:**Exclusion Criteria:**

FDA labeled contraindications to the requested agent

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

High Risk Medication PA - Benztropine

Drug Name(s)

Benztropine 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 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

High Risk Medication PA - Dicyclomine

Drug Name(s)

Dicyclomine 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

High Risk Medication PA - Hydroxyzine

Drug Name(s)

Hydroxyzine 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

High Risk Medication PA - Lomotil

Drug Name(s)

Diphenoxylate/Atropine

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

High Risk Medication PA - Scopolamine

Drug Name(s)

Scopolamine

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

High Risk Medication PA - Trihexyphenidyl

Drug Name(s)

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:

Injectable Oncology PA - Firmagon

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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Ivermectin Tablet PA

Drug Name(s)

Ivermectin Tab

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 BOTH 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

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

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Kalydeco PA

Drug Name(s)

Kalydeco

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

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:

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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:

Pending CMS Review

Prior Authorization Group Description:

Lidocaine Topical PA - Lidocaine Patch

Drug Name(s)

Lidocaine Patch

Lidocan

Tridacaine

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. Another diagnosis that is supported in CMS approved compendia for the requested agent
- AND

2. ONE of the following:

- A. Patient has tried and had an inadequate response to a conventional therapy [e.g., gabapentin, pregabalin, oral prescription NSAID (non-steroidal anti-inflammatory drug)] for the requested indication OR
- B. Patient has an intolerance or hypersensitivity to a conventional therapy OR
- C. Patient has an FDA labeled contraindication to a conventional therapy

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Lupron Depot PA

Drug Name(s)

Lupron Depot (1-Month)

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Lupron Depot Ped PA

Drug Name(s)

Lupron Depot-Ped (1-Month)

Lupron Depot-Ped (3-Month)

Lupron Depot-Ped (6-Month)

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Lupron PA

Drug Name(s)

Leuprolide Acetate (Lupron)

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Lutrate Depot PA

Drug Name(s)

Leuprolide Acetate (Lutrate Depot)

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Memantine PA

Drug Name(s)

Memantine Hcl

Memantine Hcl Titration Pak

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Metyrosine PA

Drug Name(s)

Metyrosine

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., endocrinologist, 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Migranal PA

Drug Name(s)

Dihydroergotamine Mesylate

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, 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, acute CGRP)

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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 initial approval require BOTH of the following:

1. ONE of the following:
 - A. Patient has a diagnosis of excessive sleepiness associated with narcolepsy as confirmed by a sleep study OR
 - B. Patient has a diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA) as confirmed by a sleep study OR
 - C. Patient has another 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)

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 excessive sleepiness associated with narcolepsy OR
 - B. Patient has a diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA) OR
 - C. Patient has another 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 target agent (i.e., armodafinil)

Age Restriction:

Patient is 18 years of age or over

Prescriber Restrictions:**Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 therapy (DMT) 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 therapy (DMT) or a biologic immunomodulator for the requested indication

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 therapy (DMT) 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 therapy (DMT) or a biologic immunomodulator for the requested indication

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 therapy (DMT) 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 therapy (DMT) or a biologic immunomodulator for the requested indication

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 therapy (DMT) 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 therapy (DMT) or a biologic immunomodulator for the requested indication

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 therapy (DMT) 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 therapy (DMT) or a biologic immunomodulator for the requested indication

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 therapy (DMT) 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 therapy (DMT) or a biologic immunomodulator for the requested indication

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 therapy (DMT) 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 therapy (DMT) or a biologic immunomodulator for the requested indication

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 therapy (DMT) 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 therapy (DMT) or a biologic immunomodulator for the requested indication

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Nexletol PA

Drug Name(s)

Nexletol

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Nexlizet PA

Drug Name(s)

Nexlizet

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Nintedanib PA

Drug Name(s)

Nintedanib Esylate

Ofev

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Nitisinone PA

Drug Name(s)

Nitisinone

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 Hereditary Tyrosinemia Type 1 (HT-1) evidenced by ONE of the following:
 - A. A confirmed laboratory detection of succinylacetone (SA) in urine or blood OR
 - B. Genetic testing confirming biallelic pathogenic or likely pathogenic variants in the fumarylacetoacetate hydrolase (FAH) gene 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 Hereditary Tyrosinemia Type 1 (HT-1) 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., endocrinologist, hepatologist, 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Nucala PA

Drug Name(s)

Nucala

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 chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype AND the following:

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

C. 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

D. Patient has a diagnosis of hypereosinophilic syndrome (HES) for 6 months or more 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 OR

E. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) 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, Exdensus, Fasenra) 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 COPD and an eosinophilic phenotype, patient is 18 years of age or over. For diagnosis of EGPA, patient is 18 years of age or over. For diagnosis of HES, patient is 12 years of age or over. For diagnosis of CRSwNP, patient is 18 years of age or over.

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, otolaryngologist, pathologist, 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 chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype AND the following:
 - i. Patient is currently being treated with AND will continue COPD control therapy (e.g., ICS, LABA, LAMA) in combination with the requested agent OR
 - C. 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
 - D. Patient has a diagnosis of hypereosinophilic syndrome (HES) for 6 months or more without an identifiable non-hematologic secondary cause 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
 - E. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) 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, Exdensusur, Fasenra) for the requested indication

Part B Prerequisite:

No

Prerequisite Therapy Required:

Yes

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Nurtec PA

Drug Name(s)

Nurtec

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Omnipod PA

Drug Name(s)

Omnipod Go

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Opioids ER PA - Fentanyl Patch

Drug Name(s)

Fentanyl

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:
Yes

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:
Yes

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:

Otezla PA

Drug Name(s)

Otezla

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

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:

Pending CMS Review

Prior Authorization Group Description:

Ozempic Inj 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Ozempic Tablet PA

Drug Name(s)

Ozempic Tab

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Pegasys 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

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Pirfenidone PA

Drug Name(s)

Pirfenidone

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Posaconazole PA

Drug Name(s)

Posaconazole Dr

Indications:

All Medically-Accepted Indications.

Off-Label Uses:**Exclusion Criteria:**

FDA labeled contraindications to the requested agent

Required Medical Information:

Pending CMS Review

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:

Pending CMS Review

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:

Pending CMS Review

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:

Pending CMS Review

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:

Pending CMS 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:

Pending CMS Review

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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. 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:

Pending CMS Review

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., 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:

Pending CMS Review

Prior Authorization Group Description:

Rezurock PA

Drug Name(s)

Rezurock

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 chronic graft-versus-host disease (chronic GVHD) AND
2. Patient has failed at least two prior lines of systemic therapy

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of chronic graft-versus-host disease (chronic GVHD) 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., hematologist, 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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:

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:

Rufinamide PA

Drug Name(s)

Rufinamide

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Rybelsus PA

Drug Name(s)

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Sapropterin PA

Drug Name(s)

Sapropterin Dihydrochloride

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) or Sephience (sepiapterin) 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) or Sephience (sepiapterin) 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:

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Afinitor

Drug Name(s)

Everolimus Tab

Torpenz

Yulithira

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Afinitor Disperz

Drug Name(s)

Everolimus Tab (for Oral Susp)

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Akeega

Drug Name(s)

Akeega

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Alecensa

Drug Name(s)

Alecensa

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Alunbrig

Drug Name(s)

Alunbrig

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Augtyro

Drug Name(s)

Augtyro

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Avmapki Fakzynja

Drug Name(s)

Avmapki Fakzynja Co-Pack

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Ayvakit

Drug Name(s)

Ayvakit

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Balversa

Drug Name(s)

Balversa

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Besremi

Drug Name(s)

Besremi

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Bosulif Capsule

Drug Name(s)

Bosulif Cap

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Bosulif Tablet

Drug Name(s)

Bosulif Tab

Bosutinib Tab

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Braftovi

Drug Name(s)

Braftovi

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Brukinsa

Drug Name(s)

Brukinsa

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Cabometyx

Drug Name(s)

Cabometyx

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Calquence

Drug Name(s)

Calquence

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Caprelsa

Drug Name(s)

Caprelsa

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Cavhanza

Drug Name(s)

Cavhanza

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Cometriq

Drug Name(s)

Cometriq

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Copiktra

Drug Name(s)

Copiktra

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Cotellic

Drug Name(s)

Cotellic

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Danziten

Drug Name(s)

Danziten

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Daurismo

Drug Name(s)

Daurismo

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Ensacove

Drug Name(s)

Ensacove

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Erivedge

Drug Name(s)

Erivedge

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Erleada

Drug Name(s)

Erleada

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Fotivda

Drug Name(s)

Fotivda

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Fruzaqla

Drug Name(s)

Fruzaqla

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Gavreto

Drug Name(s)

Gavreto

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Gilotrif

Drug Name(s)

Gilotrif

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Gleevec

Drug Name(s)

Imatinib Mesylate

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Gomekli

Drug Name(s)

Gomekli

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Hernexeos

Drug Name(s)

Hernexeos

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Hyrnuo

Drug Name(s)

Hyrnuo

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Ibrance

Drug Name(s)

Ibrance

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Ibtrozi

Drug Name(s)

Ibtrozi

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Iclusig

Drug Name(s)

Iclusig

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Idhifa

Drug Name(s)

Idhifa

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Imbruvica

Drug Name(s)

Imbruvica

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Imkeldi

Drug Name(s)

Imkeldi

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Inluriyo

Drug Name(s)

Inluriyo

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Inlyta

Drug Name(s)

Inlyta

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Inqovi

Drug Name(s)

Inqovi

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Inrebic

Drug Name(s)

Inrebic

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Iressa

Drug Name(s)

Gefitinib

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Itovebi

Drug Name(s)

Itovebi

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Iwifin

Drug Name(s)

Iwifin

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Jakafi

Drug Name(s)

Jakafi

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Jaypirca

Drug Name(s)

Jaypirca

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Kisqali

Drug Name(s)

Kisqali

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Komzifti

Drug Name(s)

Komzifti

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Koselugo

Drug Name(s)

Koselugo

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Krazati

Drug Name(s)

Krazati

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Lazcluze

Drug Name(s)

Lazcluze

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Lenvima

Drug Name(s)

Lenvima

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Lifyorli

Drug Name(s)

Lifyorli

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Lonsurf

Drug Name(s)

Lonsurf

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Lorbrena

Drug Name(s)

Lorbrena

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Lumakras

Drug Name(s)

Lumakras

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Lynparza

Drug Name(s)

Lynparza

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Lytgobi

Drug Name(s)

Lytgobi

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Matulane

Drug Name(s)

Matulane

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Mekinist

Drug Name(s)

Mekinist

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Mektovi

Drug Name(s)

Mektovi

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Modeyso

Drug Name(s)

Modeyso

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Nerlynx

Drug Name(s)

Nerlynx

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Nexavar

Drug Name(s)

Sorafenib

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Ninlaro

Drug Name(s)

Ninlaro

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Nubeqa

Drug Name(s)

Nubeqa

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Odomzo

Drug Name(s)

Odomzo

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Ogsiveo

Drug Name(s)

Ogsiveo

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Ojemda

Drug Name(s)

Ojemda

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Ojjaara

Drug Name(s)

Ojjaara

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Onureg

Drug Name(s)

Onureg

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Orgovyx

Drug Name(s)

Orgovyx

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Orserdu

Drug Name(s)

Orserdu

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Pemazyre

Drug Name(s)

Pemazyre

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Piqray

Drug Name(s)

Piqray

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Pomalyst

Drug Name(s)

Pomalidomide

Pomalyst

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Qinlock

Drug Name(s)

Qinlock

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Retevmo

Drug Name(s)

Retevmo

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Revlimid

Drug Name(s)

Lenalidomide

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Revuforj

Drug Name(s)

Revuforj

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Rezlidhia

Drug Name(s)

Rezlidhia

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Romvimza

Drug Name(s)

Romvimza

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Rozlytrek

Drug Name(s)

Rozlytrek

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Rubraca

Drug Name(s)

Rubraca

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Rydapt

Drug Name(s)

Rydapt

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Scemblix

Drug Name(s)

Scemblix

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Sprycel

Drug Name(s)

Dasatinib

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Stivarga

Drug Name(s)

Stivarga

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Sutent

Drug Name(s)

Sunitinib Malate

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Tabrecta

Drug Name(s)

Tabrecta

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Tafenlar

Drug Name(s)

Tafenlar

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Tagrisso

Drug Name(s)

Tagrisso

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Talzenna

Drug Name(s)

Talzenna

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Tarceva

Drug Name(s)

Erlotinib Hcl

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Targretin Capsule

Drug Name(s)

Bexarotene Cap

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Tassigna

Drug Name(s)

Nilotinib

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Tepmetko

Drug Name(s)

Tepmetko

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Thalomid

Drug Name(s)

Thalomid

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Tibsovo

Drug Name(s)

Tibsovo

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Tretinoin Capsule

Drug Name(s)

Tretinoin Cap

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Truqap

Drug Name(s)

Truqap

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Tukysa

Drug Name(s)

Tukysa

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Turalio

Drug Name(s)

Turalio

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Tykerb

Drug Name(s)

Lapatinib Ditosylate

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Vanflyta

Drug Name(s)

Vanflyta

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Venclexta

Drug Name(s)

Venclexta

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Veppanu

Drug Name(s)

Veppanu

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Verzenio

Drug Name(s)

Verzenio

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Vitrakvi

Drug Name(s)

Vitrakvi

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Vizimpro

Drug Name(s)

Vizimpro

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Vonjo

Drug Name(s)

Vonjo

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Voranigo

Drug Name(s)

Voranigo

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:
Self Administered Oncology PA - Votrient

Drug Name(s)

Pazopanib Hcl

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Welireg

Drug Name(s)

Welireg

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Xalkori

Drug Name(s)

Xalkori

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Xospata

Drug Name(s)

Xospata

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Xpovio

Drug Name(s)

Xpovio

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Xtandi

Drug Name(s)

Xtandi

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Yonsa

Drug Name(s)

Yonsa

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Zejula

Drug Name(s)

Zejula

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Zelboraf

Drug Name(s)

Zelboraf

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Zolinda

Drug Name(s)

Zolinda

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Self Administered Oncology PA - Zydelig

Drug Name(s)

Zydelig

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 are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Zykadia

Drug Name(s)

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. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Self Administered Oncology PA - Zytiga

Drug Name(s)

Abiraterone Acetate

Abirtega

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Sirturo PA

Drug Name(s)

Sirturo

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 pulmonary tuberculosis (TB) due to Mycobacterium tuberculosis resistant to at least rifampin and isoniazid AND
2. The requested agent will be used in combination with other anti-infectives 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:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., infectious disease, 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

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 as confirmed by a sleep study OR

B. BOTH of the following:

i. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness as confirmed by a sleep study 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:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist, psychiatrist, sleep 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:

Part B Prerequisite:

No

Prerequisite Therapy Required:

Yes

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:

Pending CMS Review

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:

Pending CMS Review

Prior Authorization Group Description:

Tarpeyo PA

Drug Name(s)

Tarpeyo

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

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 initial 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

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. 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) AND
 - ii. The requested agent is being used to treat nighttime sleep disturbances associated with SMS AND
3. Patient has had clinical benefit with the requested agent

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Teriparatide PA

Drug Name(s)

Bonsity

Teriparatide

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Testosterone Topical Gel PA

Drug Name(s)

Testosterone Gel

Testosterone Pump

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Pending CMS Review

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:

Pending CMS Review

Prior Authorization Group Description:

Tobi Podhaler PA

Drug Name(s)

Tobi Podhaler

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 56 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam) OR
 - b. Patient is currently (within the past 56 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

Age Restriction:**Prescriber Restrictions:****Coverage Duration:**

Approval will be for 12 months

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 56 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam) OR
 - b. Patient is currently (within the past 56 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**

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

Other Criteria:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Topical Retinoids PA - Tazarotene

Drug Name(s)

Tazarotene

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Topical Retinoids PA - Tretinoin

Drug Name(s)

Tretinoin (Topical)

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Trintine PA

Drug Name(s)

Trintine Hcl

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Trikafta PA

Drug Name(s)

Trikafta

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Tymlos PA

Drug Name(s)

Tymlos

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Urea Cycle Disorders PA - Buphenyl

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 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

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Valchlor PA

Drug Name(s)

Valchlor

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:

Pending CMS Review

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Vowst PA

Drug Name(s)

Vowst

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Wegovy Inj PA

Drug Name(s)

Wegovy Inj

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Requested agent will be used for weight loss alone AND FDA labeled contraindications to the requested agent

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Wegovy Tablet PA

Drug Name(s)

Wegovy Tab

Indications:

All FDA-Approved Indications.

Off-Label Uses:**Exclusion Criteria:**

Requested agent will be used for weight loss alone AND FDA labeled contraindications to the requested agent

Required Medical Information:

Pending CMS Review

Prior Authorization Group Description:

Xdemvy PA

Drug Name(s)

Xdemvy

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:

Xifaxan 200 MG Tablet PA

Drug Name(s)

Xifaxan 200Mg

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 traveler's diarrhea (TD) AND
2. Patient's traveler's diarrhea is caused by noninvasive strains of Escherichia coli AND
3. Patient's diarrhea is not complicated by fever or blood in the stool

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

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 spontaneous urticaria (CSU) AND BOTH of the following:

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

ii. ONE of the following:

a. Patient has tried and had an inadequate response to 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 spontaneous 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 for 12 months

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, Rhapsido, or an injectable Interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Exdensusur, Fasentra, 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 spontaneous 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, Rhapsido, or an injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Exdensur, Fasenra, Nucala) for the requested indication AND
4. The requested dose is within FDA labeled dosing for the requested indication

Part B Prerequisite:

No

Prerequisite Therapy Required:

Yes

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 BOTH of 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 AND

2. Patient has a body surface area (BSA) of greater than or equal to 0.39 m^2

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 a body surface area (BSA) of greater than or equal to 0.39 m^2 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:

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:**Part B Prerequisite:**

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:

Ztalmy PA

Drug Name(s)

Ztalmy

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Pending CMS Review



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, 2028, and from time to time during the year.

This document includes EmblemHealth Medicare PDP partial formulary as of January 1, 2027. 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](http://www.emblemhealth.com/medicare)**.

27042v08