El Paso Health Advantage Dual SNP (HMO SNP) Medicare Part D Plan

Prior Authorization Criteria
Last Updated 11/1/2021

Products Affected

- *adapalene 0.1% cream*
- *adapalene 0.3% gel*
- *avita 0.025% cream*
- EPIDUO 0.3-2.5% GEL
- *tretinoin 0.025% cream*
- *tretinoin 0.04% gel*
- *tretinoin 0.05% gel*
- *tretinoin 0.1% gel*
- *adapalene 0.1% gel*
- *adapalene/benzoyl peroxide 0.1-2.5% gel*
- *avita 0.025% gel*
- *tretinoin 0.01% gel*
- *tretinoin 0.025% gel*
- *tretinoin 0.05% cream*
- *tretinoin 0.1% cream*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ACTEMRA 162MG/0.9ML AUTO-INJECTOR
- ACTEMRA 162MG/0.9ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) For rheumatoid arthritis: Intolerance to or failure of therapy with 2 of the following: a) Enbrel, b) Humira c) Rinvoq OR d) Xeljanz. B) For polyarticular juvenile idiopathic arthritis: Intolerance to or failure of therapy with 2 of the following: a) Humira b) Enbrel OR c) Xeljanz. C) For Giant Cell Arteritis: trial and failure of corticosteroids required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ACTIMMUNE 2000000UNIT/0.5ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Hematologist, Immunologist, Endocrinologist, infectious disease specialist or Genetic Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *alyq 20mg tab*
- *tadalafil 20mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist or cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ADEMPAS 0.5MG TAB
- ADEMPAS 1MG TAB
- ADEMPAS 2MG TAB
- ADEMPAS 1.5MG TAB
- ADEMPAS 2.5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) Diagnosis confirmed by right heart catheterization. B) For pulmonary arterial hypertension: Intolerance to, or failure of, therapy with both of the following: one ERA (ambrisentan, bosentan or macitentan (Opsumit)) AND one PDE5-inhibitor (sildenafil or tadalafil). C) For persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4), no prior therapy required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist or cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *everolimus 10mg tab (New Starts Only)*
- *everolimus 2mg tab for oral susp (New Starts Only)*
- *everolimus 5mg tab (New Starts Only)*
- *everolimus 7.5mg tab (New Starts Only)*
- *everolimus 2.5mg tab (New Starts Only)*
- *everolimus 3mg tab for oral susp (New Starts Only)*
- *everolimus 5mg tab for oral susp (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- AIMOVIG 140MG/ML AUTO-INJECTOR
- AIMOVIG 70MG/ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Both of the following: A) Member has 4 or more migraine days per month for the previous 3 months or longer AND B) Member has tried and failed an 8-week or greater trial of 2 of the 3 following drug classes: a) anticonvulsants, b) vasoactive agents, OR c) antidepressants. For continuation requests: Prescriber attests to improvement in the member's condition with use of Aimovig.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, pain specialist or headache specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Headache specialist defined as a member of the United Council for Neurologic Subspecialties, American Headache Society, National Headache Foundation, or International Headache Society OR has a certificate of added qualification in headache medicine or by the American Board of Headache Management.

Products Affected

– ALECENSA 150MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– *nitazoxanide 500mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For diarrhea due to giardiasis: trial of metronidazole is required. For diarrhea due to cryptosporidiosis, trial of metronidazole NOT required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ALUNBRIG 180MG TAB (New Starts Only)
- ALUNBRIG 30MG TAB (New Starts Only)
- ALUNBRIG 90MG TAB (New Starts Only)
- ALUNBRIG INITIATION PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- APTIOM 200MG TAB (New Starts Only)
- APTIOM 400MG TAB (New Starts Only)
- APTIOM 600MG TAB (New Starts Only)
- APTIOM 800MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ARCALYST 220MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatology specialist, dermatology specialist or immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ARIKAYCE 590MG/8.4ML INH SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has failed to achieve negative sputum cultures after at least 6 months of multidrug regimen therapy for MAC lung disease.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist or pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– AURYXIA 210MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- AUSTEDO 12MG TAB
- AUSTEDO 6MG TAB
- AUSTEDO 9MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) For tardive dyskinesia: i) Member has failed to respond to a change, or is unable to switch current antidopaminergic therapy. B) For chorea associated with Huntington's disease: Member has intolerance to, or failure of therapy with, tetrabenazine.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or psychiatrist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- AYVAKIT 100MG TAB (New Starts Only)
- AYVAKIT 200MG TAB (New Starts Only)
- AYVAKIT 25MG TAB (New Starts Only)
- AYVAKIT 300MG TAB (New Starts Only)
- AYVAKIT 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For unresectable or metastatic gastrointestinal stromal tumor: Documentation is provided of PDGFRA exon 18 mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist, allergist, or immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BALVERSA 3MG TAB (New Starts Only)
- BALVERSA 4MG TAB (New Starts Only)
- BALVERSA 5MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of susceptible FGFR2 or FGFR3 genetic alteration, as detected by an FDA approved test.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BANZEL 40MG/ML SUSP (New Starts Only)
- *rufinamide 200mg tab (New Starts Only)*
- *rufinamide 400mg tab (New Starts Only)*
- *rufinamide 40mg/ml susp (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of at least one anti-epileptic medication was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– BAXDELA 450MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BENLYSTA 200MG/ML AUTO-INJECTOR
- BENLYSTA 200MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Member has severe active CNS lupus OR member is taking IV cyclophosphamide or other biologics.
Required Medical Info	For systemic lupus erythematosus initial therapy: A) Member is required to be taking a concurrent corticosteroid unless contraindicated AND B) Trial and failure of one of the following: a) hydroxychloroquine, b) methotrexate, c) azathioprine OR d) mycophenolate. For continuation therapy (all diagnoses): Documentation is provided of disease improvement.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatologist, nephrologist, or dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For initial therapy: Diagnosis of active systemic lupus erythematosus is confirmed by one of the following: anti-double stranded DNA value greater than 30 IU/mL OR low complement (C3/C4). For continuation therapy: lab values not required.

Products Affected

- BENZNIDAZOLE 100MG TAB
- BENZNIDAZOLE 12.5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for 3 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BOSULIF 100MG TAB (New Starts Only)
- BOSULIF 400MG TAB (New Starts Only)
- BOSULIF 500MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– BRAFTOVI 75MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BRIVIACT 100MG TAB (New Starts Only)
- BRIVIACT 10MG/ML ORAL SOLN (New Starts Only)
- BRIVIACT 50MG TAB (New Starts Only)
- BRIVIACT 10MG TAB (New Starts Only)
- BRIVIACT 25MG TAB (New Starts Only)
- BRIVIACT 75MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– BRUKINSA 80MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CABLIVI 11MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) Member has received or will receive the first dose of caplacizumab while undergoing plasma exchange for acquired thrombotic thrombocytopenic purpura. B) Prescriber attests that patient will be monitored and therapy continued beyond 30 days post-plasma exchange only if ADAMTS23 levels remain less than 10%.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for 4 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CABOMETYX 20MG TAB (New Starts Only)
- CABOMETYX 40MG TAB (New Starts Only)
- CABOMETYX 60MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation, with an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *calcipotriene 0.005% cream*
- *calcipotriene 0.005% ointment*
- *calcipotriene 0.005% topical soln*
- *calcipotriene/betamethasone 0.005-0.064% ointment*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CALQUENCE 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CAPLYTA 42MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed 2 of the following: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone OR e) ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CAPRELSA 100MG TAB (New Starts Only)
- CAPRELSA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an endocrinologist or oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CARBAGLU 200MG TAB FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CAYSTON 75MG INH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist or pulmonology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CERDELGA 84MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a medical geneticist or metabolic physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CHOLBAM 250MG CAP
- CHOLBAM 50MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hepatologist or pediatric gastroenterologist.
Coverage Duration	Initial will be 3 months, then if criteria is met approved for the rest of the plan year.
Other Criteria	Renewal requires documentation is provided of stable or improved liver function.

Products Affected

- CIMZIA 200MG INJ
- CIMZIA 200MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Rheumatoid Arthritis (RA): Intolerance to or failure of therapy with 2 of the following: a) Humira, b) Enbrel c) Rinvoq OR d) Xeljanz. For Ankylosing Spondylitis (AS): Intolerance to or failure of therapy with 2 of the following: a) Humira, b) Enbrel OR c) Taltz. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Stelara, e) Otezla OR f) Xeljanz. For Plaque Psoriasis: Intolerance to or failure of therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Skyrizi, e) Stelara OR f) Otezla. For Crohn's Disease: Intolerance to or failure of therapy with both of the following: a) Humira AND b) Stelara. For Non-radiographic axial spondyloarthritis: Intolerance or failure of therapy with two non-steroidal anti-inflammatory drugs (NSAIDs).
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis, Non-radiographic axial spondyloarthritis or Ankylosing Spondylitis: Prescribed by, or in consultation, with a rheumatology specialist. For Crohn's Disease: Prescribed by, or in consultation with, a gastroenterology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- COMETRIQ 100MG DAILY DOSE CARTON PACK (New Starts Only)
- COMETRIQ 140MG DAILY DOSE CARTON PACK (New Starts Only)
- COMETRIQ 60MG DAILY DOSE CARTON PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- COPIKTRA 15MG CAP (New Starts Only)
- COPIKTRA 25MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CORLANOR 5MG TAB
- CORLANOR 7.5MG TAB
- CORLANOR 5MG/5ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	One of the following: A) Member is on a maximally tolerated dose of beta blocker OR B) Member has a history of intolerance, contraindication, or a hypersensitivity to beta blocker.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a cardiology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– COTELLIC 20MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CYSTADROPS 0.37% OPHTH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an ophthalmologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CYSTARAN 0.44% OPHTH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an ophthalmologist or medical geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- DAURISMO 100MG TAB (New Starts Only)
- DAURISMO 25MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- DIACOMIT 250MG CAP (New Starts Only)
- DIACOMIT 500MG CAP (New Starts Only)
- DIACOMIT 250MG POWDER FOR ORAL SUSP (New Starts Only)
- DIACOMIT 500MG POWDER FOR ORAL SUSP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- DOPTELET 20MG TAB
- DOPTELET 40MG DAILY DOSE PACK
- DOPTELET 60MG DAILY DOSE PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For thrombocytopenia with chronic liver disease and scheduled to undergo a procedure: Member has a platelet count from the prior two weeks that shows less than 50,000 platelets per microliter.
Age Restrictions	
Prescriber Restriction	For chronic immune thrombocytopenia: Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *dronabinol 10mg cap*
- *dronabinol 2.5mg cap*
- *dronabinol 5mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Products Affected

- DUPIXENT 200MG/1.14ML AUTO-INJECTOR
- DUPIXENT 200MG/1.14ML SYRINGE
- DUPIXENT 300MG/2ML AUTO-INJECTOR
- DUPIXENT 300MG/2ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Atopic Dermatitis: Intolerance to, or failure of therapy of two (2) of the following: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant. For Asthma: Prescriber attests that member has a history, within the last year, of at least 1 asthma exacerbation requiring one of the following: a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For nasal polyps: Intolerance to, or failure of therapy of both of the following: a) an oral corticosteroid AND b) a nasal corticosteroid. For continuation requests (all diagnoses): Prescriber attests to improvement in the member's condition with use of Dupixent.
Age Restrictions	For Atopic Dermatitis: Member must be 6 years of age or older. For Asthma: Member must be 12 years of age or older. For Nasal polyps: Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with, an allergist, immunologist, pulmonologist, dermatologist or ENT specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For atopic dermatitis: Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For asthma: Member has one of the following: 1) moderate to severe asthma with an eosinophilic phenotype (baseline blood eosinophil concentration is provided and is greater than or equal to 150 cells/mL) OR 2) member has oral corticosteroid-dependent asthma. For nasal polyps, both of the following: A) Bilateral nasal polyposis confirmed with sinus CT scan AND B) Prescriber attests to moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain).

Products Affected

- EMGALITY 100MG/ML SYRINGE
- EMGALITY 120MG/ML SYRINGE
- EMGALITY 120MG/ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Both of the following: A) Member has 4 or more migraine days per month for the previous 3 months or longer AND B) Member has tried and failed an 8-week or greater trial of 2 of the 3 following drug classes: a) anticonvulsants, b) vasoactive agents, OR c) antidepressants. For episodic cluster headache prophylaxis: Member has tried and failed verapamil. For continuation requests (all diagnoses): Prescriber attests to improvement in the member's condition with use of Emgality.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, pain specialist or headache specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Headache specialist defined as a member of the United Council for Neurologic Subspecialties, American Headache Society, National Headache Foundation, or International Headache Society OR has a certificate of added qualification in headache medicine or by the American Board of Headache Management.

Products Affected

- ENBREL 25MG INJ
- ENBREL 25MG/0.5ML INJ
- ENBREL 25MG/0.5ML SYRINGE
- ENBREL 50MG/ML AUTO-INJECTOR
- ENBREL 50MG/ML CARTRIDGE
- ENBREL 50MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 20mg/week required (or maximally tolerated dose). For Juvenile Idiopathic Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose). For Plaque Psoriasis: Failure of, or intolerance to therapy with one of the following: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) soriatane. For Ankylosing Spondylitis (AS): Failure of, or intolerance to sulfasalazine (Trial of sulfasalazine not required for AS with predominant axial involvement). For Psoriatic Arthritis: Failure of, or intolerance to one of the following: a) methothrexate OR b) sulfasalazine.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ENDARI 5GM POWDER FOR ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1. Trial of maximally tolerated hydroxyurea dose was ineffective, not tolerated or contraindicated. 2. Member has had at least 1 vaso-occlusive crises in the prior 12 months, while on hydroxyurea (if applicable). 3. If prescriber is a hematologist at a Sickle Cell Center of Excellence, criteria 1 and 2 may be bypassed (Documentation is provided of the name of the center of excellence)
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ENSPRYNG 120MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of a positive test for anti-aquaporin-4 antibodies.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, ophthalmologist, or neuro-ophthalmologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Will not be used in combination with eculizumab (Soliris) or inebilizumab (Uplinza).

Products Affected

– SOFOSBUVIR 400MG/VELPATASVIR 100MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer is provided 3) Documentation is provided that member does or does not have cirrhosis 4) Previous Hepatitis C Treatment(s) is provided.
Age Restrictions	Member must be 6 years of age or older (or weight at least 17 kg).
Prescriber Restriction	Prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease or transplant specialist.
Coverage Duration	Coverage duration of 12 weeks.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected

– EPIDIOLEX 100MG/ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of at least 1 anti-epileptic medication was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ERIVEDGE 150MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For locally advanced basal cell carcinoma: Trial of Odomzo was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ERLEADA 60MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic castration-sensitive prostate cancer (mCSPC): failure of or intolerance to abiraterone (Zytiga equivalent) required. For nonmetastatic castration-resistant prostate cancer (nmCRPC): no prior agent trial required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ESBRIET 267MG CAP
- ESBRIET 267MG TAB
- ESBRIET 801MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For idiopathic pulmonary fibrosis: Diagnosis confirmed by both of the following: A) No known cause of lung fibrosis AND B) One of the following: 1) Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) 2) High-resolution computed tomography indicates definite UIP pattern 3) Both High-resolution computed tomography indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– EVRYSDI 0.75MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of a genetic test confirming diagnosis of spinal muscular atrophy.
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Will not be used in combination with nusinersen (Spinraza).

Products Affected

- FANAPT 10MG TAB (New Starts Only)
- FANAPT 12MG TAB (New Starts Only)
- FANAPT 1MG TAB (New Starts Only)
- FANAPT 2MG TAB (New Starts Only)
- FANAPT 4MG TAB (New Starts Only)
- FANAPT 6MG TAB (New Starts Only)
- FANAPT 8MG TAB (New Starts Only)
- FANAPT TITRATION PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed 2 of the following: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone OR e) ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FARYDAK 10MG CAP (New Starts Only)
- FARYDAK 15MG CAP (New Starts Only)
- FARYDAK 20MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FASENRA 30MG/ML AUTO-INJECTOR
- FASENRA 30MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) Peripheral blood eosinophil count is provided and greater than or equal to 150 cells per microliter. B) History of one (1) or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s).
Age Restrictions	Member must be 12 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with, an allergy specialist, immunologist, or pulmonary specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *deferiprone 500mg tab*
- FERRIPROX 100MG/ML ORAL SOLN
- FERRIPROX 1000MG TAB
- FERRIPROX 500MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– FINTEPLA 2.2MG/ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of at least 1 anti-epileptic medication was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FIRMAGON 120MG INJ (New Starts Only)
- FIRMAGON 80MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FOTIVDA 0.89MG CAP (New Starts Only)
- FOTIVDA 1.34MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FYCOMPA 0.5MG/ML SUSP (New Starts Only)
- FYCOMPA 10MG TAB (New Starts Only)
- FYCOMPA 12MG TAB (New Starts Only)
- FYCOMPA 2MG TAB (New Starts Only)
- FYCOMPA 4MG TAB (New Starts Only)
- FYCOMPA 6MG TAB (New Starts Only)
- FYCOMPA 8MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For partial-onset seizures: Member tried and failed both of the following: a) topiramate AND b) Vimpat (lacosamide). For primary generalized tonic-clonic seizures: Member tried and failed two of the following: a) lamotrigine, b) levetiracetam, c) primidone OR d) topiramate.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or epilepsy specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– GALAFOLD 28 DAY WALLET 123MG PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided that member has an amenable glactosidase alpha gene (GLA) variant.
Age Restrictions	Member must be 16 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with, a medical geneticist, nephrologist or a prescriber specialized in the treatment of Fabry disease.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– GATTEX 5MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is dependent on parenteral support for at least 12 months and at least 3 days per week.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– GAVRETO 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of RET gene fusion.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- GILOTRIF 20MG TAB (New Starts Only)
- GILOTRIF 30MG TAB (New Starts Only)
- GILOTRIF 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- GENOTROPIN 0.2MG SYRINGE
- GENOTROPIN 0.4MG SYRINGE
- GENOTROPIN 0.6MG SYRINGE
- GENOTROPIN 0.8MG SYRINGE
- GENOTROPIN 1.2MG SYRINGE
- GENOTROPIN 1.4MG SYRINGE
- GENOTROPIN 1.6MG SYRINGE
- GENOTROPIN 1.8MG SYRINGE
- GENOTROPIN 12MG CARTRIDGE
- GENOTROPIN 1MG SYRINGE
- GENOTROPIN 2MG SYRINGE
- GENOTROPIN 5MG CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	The criteria for approval of growth hormones in adults require the diagnosis of Somatropin Deficiency Syndrome (defined by failure to stimulate Growth Hormone secretion (peak GH level of 10mcg/L or less) by one of the acceptable provocative tests). This may include adults who, as children, had Growth Hormone deficiency or adults with known pituitary disease.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BERINERT 500UNIT INJ
- CINRYZE 500UNIT INJ
- HAEGARDA 2000UNIT INJ
- HAEGARDA 3000UNIT INJ
- *icatibant 10mg/ml syringe*
- RUCONEST 2100UNIT INJ
- TAKHZYRO 300MG/2ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– HETLIOZ 20MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is totally blind.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- JUXTAPID 10MG CAP
- JUXTAPID 20MG CAP
- JUXTAPID 30MG CAP
- JUXTAPID 5MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) One of the following: i) Untreated LDL greater than 500 mg/dL OR ii) treated LDL greater than or equal to 300 mg/dL. B) Concurrent use of maximum statin dose (atorvastatin or rosuvastatin) and one other lipid lowering agent (dates and reasons for discontinuation are provided). For patients with statin intolerance, concurrent use of maximum statin dose not required. C) Documentation is provided showing the most recent full lipid panel, including Apo-B, from within the past 12 months.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a lipidologist, cardiologist, or an endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- HUMIRA 10MG/0.1ML SYRINGE
- HUMIRA 20MG/0.2ML SYRINGE
- HUMIRA 40MG/0.4ML AUTO-INJECTOR
- HUMIRA 40MG/0.4ML SYRINGE
- HUMIRA 40MG/0.8ML AUTO-INJECTOR
- HUMIRA 40MG/0.8ML SYRINGE
- HUMIRA 80MG/0.8ML AUTO-INJECTOR
- HUMIRA PEDIATRIC CROHN'S STARTER PACK (3) 80MG/0.8ML IN
- HUMIRA PEDIATRIC CROHN'S STARTER PACK SYRINGE (2) 40M
- HUMIRA PEN - CROHN'S STARTER PACK 40MG/0.8ML INJ
- HUMIRA PEN - CROHN'S STARTER PACK 80MG/0.8ML INJ
- HUMIRA PEN - PEDIATRIC UC STARTER PACK 80MG/0.8ML INJ
- HUMIRA PEN - PSORIASIS STARTER PACK 40MG/0.8ML INJ
- HUMIRA PEN - PSORIASIS STARTER PACK 80MG/0.8ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 20mg/week required (or maximally tolerated dose). For Juvenile Idiopathic Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose). For Plaque Psoriasis: Failure of, or intolerance to therapy with one of the following: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) soriatane. For Ankylosing Spondylitis (AS): Failure of, or intolerance to sulfasalazine (Trial of sulfasalazine not required for AS with predominant axial involvement). For Psoriatic Arthritis: Failure of, or intolerance to one of the following: a) methothrexate OR b) sulfasalazine. For Ulcerative Colitis or Crohn's Disease: Failure of, or intolerance to one of the following: a) corticosteroid, b) azathioprine, c) methotrexate OR d) 6-mercaptopurine. For Hidradenitis Suppurativa (HS): Member must have both of the following: a) At least 3 cysts AND b) failure of therapy with at least one (1) oral antibiotic. For Uveitis: Failure of, or intolerance to, thearpy with both of the following: a) a corticosteroid AND b) an immunosuppressant (methotrexate or cyclosporine).
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For Plaque Psoriasis and Hidradenitis Suppurativa(HS): Prescribed by, or in consultation with, a dermatology specialist. For Crohn's Disease and Ulcerative Colitis: Prescribed by, or in consultation with, a gastroenterology specialist. For Uveitis: Prescribed by, or in consult with, a rheumatology specialist OR ophthalmologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.

Other Criteria	

Products Affected

- IBRANCE 100MG CAP (New Starts Only)
- IBRANCE 125MG CAP (New Starts Only)
- IBRANCE 75MG CAP (New Starts Only)
- IBRANCE 100MG TAB (New Starts Only)
- IBRANCE 125MG TAB (New Starts Only)
- IBRANCE 75MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ICLUSIG 10MG TAB (New Starts Only)
- ICLUSIG 15MG TAB (New Starts Only)
- ICLUSIG 30MG TAB (New Starts Only)
- ICLUSIG 45MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- IDHIFA 100MG TAB (New Starts Only)
- IDHIFA 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of IDH2 mutation as detected by an FDA approved test.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- IMBRUVICA 140MG CAP (New Starts Only)
- IMBRUVICA 140MG TAB (New Starts Only)
- IMBRUVICA 280MG TAB (New Starts Only)
- IMBRUVICA 420MG TAB (New Starts Only)
- IMBRUVICA 560MG TAB (New Starts Only)
- IMBRUVICA 70MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist, hemotologist, or transplant specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– IMPAVIDO 50MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for 1 month subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– INCRELEX 40MG/4ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- INGREZZA 40MG CAP
- INGREZZA 60MG CAP
- INGREZZA 80MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) One of the following: i) Member has failed to respond to a change in current antidopaminergic therapy OR ii) Member is unable to switch current antidopaminergic therapy B) Member has a functional disability due to tardive dyskinesia.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or psychiatrist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- INLYTA 1MG TAB (New Starts Only)
- INLYTA 5MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– INQOVI 5 TABLET PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– INREBIC 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has tried and failed Jakafi.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– IRESSA 250MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ISTURISA 10MG TAB
- ISTURISA 1MG TAB
- ISTURISA 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuation requests: Documentation is provided of urinary cortisol levels that show a positive clinical response.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– *itraconazole 100mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For onychomycosis, member has failed terbinafine.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist, Pulmonary Specialist, or Dermatology Specialist.
Coverage Duration	Approved for 6 months.
Other Criteria	

Products Affected

- BIVIGAM 5GM/50ML INJ
- GAMMAGARD 10GM INJ
- GAMMAGARD 5GM INJ
- GAMMAPLEX 10GM/100ML INJ
- GAMMAPLEX 20GM/200ML INJ
- GAMUNEX 1GM/10ML INJ
- OCTAGAM 2GM/20ML INJ
- PANZYGA 1GM/10ML INJ
- PANZYGA 20GM/200ML INJ
- PANZYGA 5GM/50ML INJ
- FLEBOGAMMA 5GM/50ML INJ
- GAMMAGARD 2.5GM/25ML INJ
- GAMMAKED 1GM/10ML INJ
- GAMMAPLEX 10GM/200ML INJ
- GAMMAPLEX 5GM/50ML INJ
- OCTAGAM 1GM/20ML INJ
- PANZYGA 10GM/100ML INJ
- PANZYGA 2.5GM/25ML INJ
- PANZYGA 30GM/300ML INJ
- PRIVIGEN 20GM/200ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- JAKAFI 10MG TAB (New Starts Only)
- JAKAFI 15MG TAB (New Starts Only)
- JAKAFI 20MG TAB (New Starts Only)
- JAKAFI 25MG TAB (New Starts Only)
- JAKAFI 5MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- JYNARQUE 15MG TAB
- JYNARQUE 30MG TAB
- JYNARQUE 45/15 THERAPY PACK
- JYNARQUE 60/30 THERAPY PACK
- JYNARQUE 90/30 THERAPY PACK
- JYNARQUE TAB 15/15MG THERAPY PACK
- JYNARQUE TAB 30/15MG THERAPY PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has an eGFR of 25 ml/min/1.73m2 or greater.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KALYDECO 150MG TAB
- KALYDECO 25MG GRANULES
- KALYDECO 50MG GRANULES
- KALYDECO 75MG GRANULES

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KEVZARA 150MG/1.14ML AUTO-INJECTOR
- KEVZARA 200MG/1.14ML AUTO-INJECTOR
- KEVZARA 150MG/1.14ML SYRINGE
- KEVZARA 200MG/1.14ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis: Intolerance to, or failure of therapy with, 2 of the following: a) Humira, b) Enbrel, c) Rinvoq OR d) Xeljanz
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KISQALI 200MG DAILY DOSE PACK (New Starts Only)
- KISQALI 400MG DAILY DOSE PACK (New Starts Only)
- KISQALI 600MG DAILY DOSE PACK (New Starts Only)
- KISQALI FEMARA CO-PACK 200 PACK (New Starts Only)
- KISQALI FEMARA CO-PACK 400 PACK (New Starts Only)
- KISQALI FEMARA CO-PACK 600 PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance or contraindication to therapy with both of the following: a) Verzenio AND b) Ibrance.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– KORLYM 300MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KOSELUGO 10MG CAP (New Starts Only)
- KOSELUGO 25MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Chart notes documentation is provided that indicates inoperable and symptomatic disease
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KUVAN 100MG POWDER FOR ORAL SOLN
- KUVAN 500MG POWDER FOR ORAL SOLN
- *sapropterin 100mg tab*
- KUVAN 100MG TAB
- *sapropterin 100mg powder for oral soln*
- *sapropterin 500mg powder for oral soln*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuing therapy: member must have shown at least a 20% drop in Phenylalanine levels after 2 months of sapropterin (Kuvan) treatment.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a medical geneticist or metabolic physician.
Coverage Duration	Initial approval of 3 months. Continuing therapy approved for duration of contract year.
Other Criteria	

Products Affected

- LAMPIT 120MG TAB
- LAMPIT 30MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for 3 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- LENVIMA 10 10MG PACK (New Starts Only)
- LENVIMA 12 4MG PACK (New Starts Only)
- LENVIMA 14 PACK (New Starts Only)
- LENVIMA 18 PACK (New Starts Only)
- LENVIMA 20 10MG PACK (New Starts Only)
- LENVIMA 24 PACK (New Starts Only)
- LENVIMA 4 4MG PACK (New Starts Only)
- LENVIMA 8 4MG PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *ambrisentan 10mg tab*
- *ambrisentan 5mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a cardiologist or pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– *lidocaine 5% patch*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Management of neuropathic pain associated with diabetic peripheral neuropathy and postherpetic neuralgia.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– *lidocaine 5% ointment*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- LOKELMA 10GM POWDER FOR ORAL SUSP
- LOKELMA 5GM POWDER FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has baseline persistent potassium level greater than 5.0 mmol/L.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist, cardiologist, hematologist or endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- LONSURF 6.14-15MG TAB (New Starts Only)
- LONSURF 8.19-20MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- LORBRENA 100MG TAB (New Starts Only)
- LORBRENA 25MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- LUMAKRAS 120MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of KRAS G12C mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– LUPKYNIS 7.9MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuation therapy: Documentation is provided of disease improvement.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatologist or nephrologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Will not be used in combination with belimumab (Benlysta)

Products Affected

- LYNPARZA 100MG TAB (New Starts Only)
- LYNPARZA 150MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- MAVYRET 100-40MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer is provided 3) Documentation is provided that member does or does not have cirrhosis 4) Previous Hepatitis C Treatment(s) is provided.
Age Restrictions	Member must be 12 years of age or older, or weigh at least 45kg.
Prescriber Restriction	Prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease or transplant specialist.
Coverage Duration	Coverage duration of 8 to 16 weeks. Applied consistent with current AASLD-IDSA guidance.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected

- *megestrol acetate 125mg/ml susp*
- *megestrol acetate 40mg/ml susp*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *megestrol acetate 20mg tab (New Starts Only)*
- *megestrol acetate 40mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- MEKINIST 0.5MG TAB (New Starts Only)
- MEKINIST 2MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– MEKTOVI 15MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- MOVANTIK 12.5MG TAB
- MOVANTIK 25MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ABELCET 5MG/ML INJ
- *acetylcysteine 200mg/ml inh soln*
- *albuterol 0.21mg/ml inh soln*
- *albuterol 0.83mg/ml inh soln*
- AMBISOME 50MG INJ
- AMPHOTERICIN B 50MG INJ
- *aprepitant 125mg/aprepitant 80mg pack*
- *aprepitant 80mg cap*
- ARANESP 100MCG/ML INJ
- ARANESP 150MCG/0.3ML SYRINGE
- ARANESP 200MCG/ML INJ
- ARANESP 25MCG/ML INJ
- ARANESP 300MCG/ML INJ
- ARANESP 40MCG/ML INJ
- ARANESP 60MCG/0.3ML SYRINGE
- *arformoterol tartrate 15mcg/2ml neb soln*
- ASTAGRAF 1MG ER CAP
- AZASAN 100MG TAB
- *azathioprine 50mg tab*
- *budesonide 0.25mg/ml inh susp*
- CLINIMIX 4.25/10 INJ
- CLINIMIX 5/15 INJ
- CLINIMIX E 2.75/5 INJ
- CLINIMIX E 4.25/5 INJ
- CLINIMIX E 5/20 INJ
- CYCLOPHOSPHAMIDE 25MG CAP
- CYCLOPHOSPHAMIDE 50MG CAP
- *cyclosporine 100mg cap*
- *cyclosporine modified 100mg cap*
- *acetylcysteine 100mg/ml inh soln*
- *acyclovir 50mg/ml inj*
- *albuterol 0.417mg/ml inh soln*
- *albuterol 5mg/ml inh soln*
- AMINOSYN-PF 7% INJ
- *aprepitant 125mg cap*
- *aprepitant 40mg cap*
- ARANESP 100MCG/0.5ML SYRINGE
- ARANESP 10MCG/0.4ML SYRINGE
- ARANESP 200MCG/0.4ML SYRINGE
- ARANESP 25MCG/0.42ML SYRINGE
- ARANESP 300MCG/0.6ML SYRINGE
- ARANESP 40MCG/0.4ML SYRINGE
- ARANESP 500MCG/ML SYRINGE
- ARANESP 60MCG/ML INJ
- ASTAGRAF 0.5MG ER CAP
- ASTAGRAF 5MG ER CAP
- AZASAN 75MG TAB
- *budesonide 0.125mg/ml inh susp*
- *budesonide 0.5mg/ml inh susp*
- CLINIMIX 4.25/5 INJ
- CLINIMIX 5/20 INJ
- CLINIMIX E 4.25/10 INJ
- CLINIMIX E 5/15 INJ
- *clinisol 15% inj*
- CYCLOPHOSPHAMIDE 25MG TAB
- CYCLOPHOSPHAMIDE 50MG TAB
- *cyclosporine 25mg cap*
- *cyclosporine modified 100mg/ml oral soln*

- *cyclosporine modified 25mg cap*
- DIPHTHERIA/TETANUS TOXOID INJ
- ENGERIX-B 20MCG/ML SYRINGE
- ENVARSUS 1MG ER TAB
- *everolimus 0.25mg tab*
- *everolimus 0.75mg tab*
- *formoterol fumarate 20mcg/2ml neb soln*
- *gengraf 100mg/ml oral soln*
- *glucose 100mg/ml inj*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 0.0769 MEQ/ML INJ
- HUMULIN R 500UNIT/ML INJ
- INTRALIPID 20GM/100ML INJ
- *ipratropium/albuterol 0.5-2.5mg/3ml inh soln*
- *levalbuterol 0.21mg/ml inh soln*
- *levalbuterol 2.5mg/ml inh soln*
- *methylprednisolone 16mg tab*
- *methylprednisolone 4mg tab*
- *mycophenolate mofetil 200mg/ml susp*
- *mycophenolate mofetil 500mg tab*
- *mycophenolic acid 360mg dr tab*
- NUTRILIPID 20GM/100ML INJ
- ONDANSETRON 24MG TAB
- *ondansetron 4mg tab*
- *ondansetron 8mg tab*
- *plenamine 15% inj*
- *prednisolone 15mg odt*
- *prednisolone 30mg odt*
- *prednisone 10mg tab*
- PREDNISONE 1MG/ML ORAL SOLN
- *prednisone 20mg tab*
- *cyclosporine modified 50mg cap*
- ENGERIX-B 10MCG/0.5ML SYRINGE
- ENVARSUS 0.75MG ER TAB
- ENVARSUS 4MG ER TAB
- *everolimus 0.5mg tab*
- FIASP 100UNIT/ML INJ
- *gengraf 100mg cap*
- *gengraf 25mg cap*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 0.0342 MEQ/ML INJ
- *granisetron 1mg tab*
- IMOVAX 2.5UNIT/ML INJ
- *ipratropium bromide 0.2mg/ml inh soln*
- *levalbuterol 0.103mg/ml inh soln*
- *levalbuterol 0.417mg/ml inh soln*
- MEDROL 2MG TAB
- *methylprednisolone 32mg tab*
- *methylprednisolone 8mg tab*
- *mycophenolate mofetil 250mg cap*
- *mycophenolic acid 180mg dr tab*
- NOVOLOG 100UNIT/ML INJ
- *ondansetron 0.8mg/ml oral soln*
- *ondansetron 4mg odt*
- *ondansetron 8mg odt*
- *pentamidine isethionate 50mg/ml inh soln*
- *prednisolone 10mg odt*
- *prednisolone 1mg/ml oral soln*
- PREDNISOLONE 3MG/ML ORAL SOLN
- *prednisone 1mg tab*
- *prednisone 2.5mg tab*
- *prednisone 50mg tab*

- *prednisone 5mg tab*
- PREMASOL 10% INJ
- PROGRAF 0.2MG GRANULES FOR ORAL SUSP
- PROSOL 20% INJ
- RABAVERT 2.5UNIT/ML INJ
- RECOMBIVAX 10MCG/ML SYRINGE
- RECOMBIVAX 5MCG/0.5ML SYRINGE
- RETACRIT 20000UNIT/2ML INJ
- RETACRIT 2000UNIT/ML INJ
- RETACRIT 40000UNIT/ML INJ
- SANDIMMUNE 100MG/ML ORAL SOLN
- *sirolimus 1mg tab*
- *sirolimus 2mg tab*
- *tacrolimus 1mg cap*
- TDVAX 4-4UNIT/ML INJ
- TRAVASOL 10% INJ
- VARUBI 90MG TAB
- PREDNISONE 5MG/ML ORAL SOLN
- PROCALAMINE 3% INJ
- PROGRAF 1MG GRANULES FOR ORAL SUSP
- PULMOZYME 1MG/ML INH SOLN
- RECOMBIVAX 10MCG/ML INJ
- RECOMBIVAX 40MCG/ML INJ
- RETACRIT 10000UNIT/ML INJ
- RETACRIT 20000UNIT/ML INJ
- RETACRIT 3000UNIT/ML INJ
- RETACRIT 4000UNIT/ML INJ
- *sirolimus 0.5mg tab*
- *sirolimus 1mg/ml oral soln*
- *tacrolimus 0.5mg cap*
- *tacrolimus 5mg cap*
- TENIVAC 4-10UNIT/ML SYRINGE
- TROPHAMINE 10% INJ

PA Criteria	Criteria Details
Covered Uses	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	
Other Criteria	

Products Affected

- NATPARA 100MCG CARTRIDGE
- NATPARA 25MCG CARTRIDGE
- NATPARA 50MCG CARTRIDGE
- NATPARA 75MCG CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NERLYNX 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NEXAVAR 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NINLARO 2.3MG CAP (New Starts Only)
- NINLARO 3MG CAP (New Starts Only)
- NINLARO 4MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *droxidopa 100mg cap*
- *droxidopa 200mg cap*
- *droxidopa 300mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NOURIANZ 20MG TAB
- NOURIANZ 40MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has tried and failed one agent from both of the following classes when used in combination with carbidopa/levodopa: 1) COMT inhibitor AND 2) MAO-B inhibitor.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NOXAFIL 40MG/ML SUSP
- *posaconazole 100mg dr tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease physician or pulmonology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NUBEQA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NUCALA 100MG INJ
- NUCALA 100MG/ML AUTO-INJECTOR
- NUCALA 100MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Asthma diagnosis: A) Peripheral blood eosinophil count is provided and is greater than or equal to 150 cells per microliter. B) History of 1 or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s). For eosinophilic granulomatosis with polyangiitis (EGPA), confirmation of diagnosis required.
Age Restrictions	For Severe Asthma diagnosis: Member must be 6 years of age or older. For eosinophilic granulomatosis with polyangiitis (EGPA) diagnosis: Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with, an allergy specialist, immunologist, pulmonary specialist or rheumatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NUEDEXTA 20-10MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: A) Documentation is provided of structural neurological condition as the cause of pseudobulbar affect B) Disease severity demonstrated by a score of 13 or greater on the Center for Neurologic Study Lability Scale (CNS-LS) AND C) Member has tried and failed an SSRI. For continuation requests: A) Documentation is provided of structural neurological condition as the cause of pseudobulbar affect B) Member has demonstrated improvement while on Nuedexta, defined as one of the following: i) a score of less than 13 on the Center for Neurologic Study Lability Scale (CNS-LS) OR ii) an improvement of 7 or more points on the CNS-LS. AND C) Member has tried and failed an SSRI.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NUPLAZID 10MG TAB (New Starts Only)
- NUPLAZID 34MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NURTEC 75MG ODT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trials of 2 different triptans were ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *armodafinil 150mg tab*
- *armodafinil 200mg tab*
- *armodafinil 250mg tab*
- *armodafinil 50mg tab*
- *modafinil 100mg tab*
- *modafinil 200mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NUZYRA 150MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for 1 month subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- OCALIVA 10MG TAB
- OCALIVA 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has one of the following: a) inadequate response to a year of therapy with ursodiol OR b) experienced intolerance to ursodiol.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hepatologist or gastroenterologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ODOMZO 200MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- OFEV 100MG CAP
- OFEV 150MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) For idiopathic pulmonary fibrosis: Diagnosis confirmed by both of the following: A) No known cause of lung fibrosis AND B) One of the following: i) Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) ii) High-resolution computed tomography (HRCT) indicates definite UIP pattern iii) Both HRCT indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP. 2) For systemic sclerosis-associated iterstitial lung disease (ILD): A) Diagnosis confirmed with documentation provided of both of the following: i) HRCT scan AND ii) pulmonary function tests B) Member has tried and failed mycophenolate. 3) For chronic fibrosing ILDs with a progressive phenotype: A) Presence of reticular abnormality with traction bronchiectastis with a disease extent of more than 10% on HRCT B) Disease is progressive, defined by one of the following over the past 24 months, despite treatment: i) Forced vital capacity (FVC) decline of 10% or more OR ii) Two of the following: a) FVC decline of 5% or more b) worsening respiratory symptoms c) increasing extent of fibrotic changes on chest imaging C) Progression occurred despite treatment with one of the following: i) azathioprine ii) cyclosporine iii) mycophenolate mofetil iv) tacrolimus v) oral corticosteroids equivalent to 20 mg or more per day of prednisone vi) cyclophosphamide vii) rituximab
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist, pulmonologist, or rheumatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- OLUMIANT 1MG TAB
- OLUMIANT 2MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis: Intolerance to, or failure of therapy with, 2 of the following: a) Humira, b) Enbrel, c) Rinvoq OR d) Xeljanz
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with, a rheumatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ONUREG 200MG TAB (New Starts Only)
- ONUREG 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– OPSUMIT 10MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a cardiologist or pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FENTANYL 0.1MG BUCCAL TAB
- *fentanyl 0.2mg lozenge*
- *fentanyl 0.4mg lozenge*
- *fentanyl 0.6mg lozenge*
- *fentanyl 0.8mg lozenge*
- *fentanyl 1.6mg lozenge*
- FENTORA 200MCG BUCCAL TAB
- FENTORA 600MCG BUCCAL TAB
- FENTANYL 0.2MG BUCCAL TAB
- FENTANYL 0.4MG BUCCAL TAB
- FENTANYL 0.6MG BUCCAL TAB
- FENTANYL 0.8MG BUCCAL TAB
- *fentanyl 1.2mg lozenge*
- FENTORA 100MCG BUCCAL TAB
- FENTORA 400MCG BUCCAL TAB
- FENTORA 800MCG BUCCAL TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documented tolerance to opioids defined as patients taking around the clock medicine consisting of at least 60mg of oral morphine daily, at least 25mcg of transdermal fentanyl per hour, at least 30mg of oxycodone daily, at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid daily for a week or longer.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ORENCIA 125MG/ML AUTO-INJECTOR
- ORENCIA 125MG/ML SYRINGE
- ORENCIA 50MG/0.4ML SYRINGE
- ORENCIA 87.5MG/0.7ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis: Intolerance to, or failure of therapy with, 2 of the following: a) Enbrel, b) Humira, c) Rinvoq OR d) Xeljanz. For polyarticular juvenile idiopathic arthritis: Intolerance to, or failure of therapy with 2 of the following: a) Humira, b) Enbrel OR c) Xeljanz. For Psoriatic Arthritis: Intolerance to, or failure of therapy with, 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Stelara, e) Otezla OR f) Xeljanz.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ORENITRAM 0.125MG ER TAB
- ORENITRAM 0.25MG ER TAB
- ORENITRAM 1MG ER TAB
- ORENITRAM 2.5MG ER TAB
- ORENITRAM 5MG ER TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist or cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *nitisinone 10mg cap*
- *nitisinone 2mg cap*
- *nitisinone 5mg cap*
- ORFADIN 20MG CAP
- ORFADIN 4MG/ML SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ORGOVYX 120MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ORIAHNN 28 DAY KIT PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has failure of, or intolerance to, both of the following: a) one non-steroidal anti-inflammatory drug (NSAID) AND b) one hormonal contraceptive.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an obstetrician/gynecologist or women's health/reproductive specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Member does not have known osteoporosis.

Products Affected

- ORILISSA 150MG TAB
- ORILISSA 200MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has failure of, or intolerance to, both of the following: a) one non-steroidal anti-inflammatory drug (NSAID) AND b) one hormonal contraceptive.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an obstetrician/gynecologist or women's health/reproductive specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Member does not have known osteoporosis.

Products Affected

- ORKAMBI 125-100MG GRANULES
- ORKAMBI 125-100MG TAB
- ORKAMBI 125-200MG TAB
- ORKAMBI 188-150MG GRANULES

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– OSPHENA 60MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance to, or failure of, therapy with both of the following: a) generic estradiol vaginal cream and b) PREMARIN VAGINAL CREAM.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- OTEZLA 28-DAY STARTER PACK
- OTEZLA 30MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For oral ulcers associated with Behcet's disease: Trial of topical triamcinolone 0.1% oral paste was ineffective, not tolerated, or contraindicated. For Psoriatic Arthritis: intolerance to, or failure of therapy with, methotrexate (at least 20mg/week or maximally tolerated dose) is required. For Plaque Psoriasis: Failure of, or intolerance to, one of the following: a) methotrexate at a dose of 15mg/week (or maximally tolerated dose) OR b) soriatane.
Age Restrictions	
Prescriber Restriction	For oral ulcers associated with Behcet's disease and psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For oral ulcers associated with Behcet's disease: Diagnosis confirmed by the presence of oral ulcers AND at least two of the following: recurrent genital ulceration, eye lesions, skin lesions, positive pathergy test.

Products Affected

- OXBRYTA 500MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1. Trial of maximally tolerated hydroxyurea dose was ineffective, not tolerated or contraindicated. 2. Member has had at least 1 vaso-occlusive crisis in the prior 12 months, while on hydroxyurea (if applicable). 3. If prescriber is a hematologist at a Sickle Cell Center of Excellence, criteria 1 and 2 may be bypassed (Documentation is provided of the name of the center of excellence).
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– OXERVATE 0.002% OPHTH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Eye to be treated has never been treated with Oxervate in the past.
Age Restrictions	
Prescriber Restriction	Prescribed by an ophthalmologist.
Coverage Duration	Approved for 3 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- PALYNZIQ 10MG/0.5ML SYRINGE
- PALYNZIQ 2.5MG/0.5ML SYRINGE
- PALYNZIQ 20MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Member is 18 years of age or older.
Prescriber Restriction	Prescribed by or in consultation with, a medical geneticist or metabolic physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- PRALUENT 150MG/ML AUTO-INJECTOR
- PRALUENT 75MG/ML AUTO-INJECTOR
- REPATHA 140MG/ML AUTO-INJECTOR
- REPATHA 140MG/ML SYRINGE
- REPATHA 420MG/3.5ML CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initiation of therapy patient must: A) Have one of the following conditions: 1) prior clinical atherosclerotic cardiovascular disease (ASCVD) (see Other Criteria), 2) heterozygous familial hypercholesterolemia (HeFH) (see Other Criteria) 3) homozygous familial hypercholesterolemia (HoFH) (see Other Criteria) or 4) Primary hyperlipidemia other than HeFH and HoFH (see Other Criteria) B) Current LDL-C level is over 70 mg/dL. C) one of the following requirements is met: 1) patient has been treated for 8 weeks or more with a high intensity statin (atorvastatin 40mg or greater OR rosuvastatin 20mg or greater), OR 2) patient is intolerant to statins demonstrated by the failure of 2 statins, including an attempt with a low- or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin). Criteria B) and C) not required for HoFH. For continuation of therapy, patient must: A) have one of the following conditions: 1) prior clinical ASCVD (see Other Criteria), 2) HeFH (see Other Criteria), 3) HoFH (see Other Criteria), or 4) Primary hyperlipidemia other than HeFH and HoFH (see Other Criteria) AND B) member had a reduction in LDL-C on PCSK9 inhibitor therapy.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Clinical ASCVD defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure, prior stroke or transient ischemic attack, or peripheral arterial disease of presumed atherosclerotic origin. Diagnosis of HeFH must be confirmed by one of the following: 1) DNA-based evidence of mutation in the LDLR, Apo B, OR PCSK9 gain of function mutation, 2) Untreated LDL-C greater than 190 mg/dl AND tendon xanthomas in patient or first/second degree relative, 3) Untreated LDL-C greater than 190 mg/dl AND either first degree relative less than 60 years of age or second degree relative less than 50 years of age with premature heart disease, OR 4) untreated LDL-C greater than 190 mg/dl AND first or second degree relative with total cholesterol greater than 290 mg/dL. Diagnosis of HoFH confirmed by all of the following: 1) two parents diagnosed with HeFH or genetic confirmation of LDL

	receptor mutation, AND 2) untreated total cholesterol greater 290 mg/dL or LDL-C greater 190 mg/dL, AND 3) either xanthomas present at 10 years of age or younger or atherosclerotic disease at 20 years of age or younger. Diagnosis of primary hyperlipidemia (other than HeFH and HoFH) includes documentation provided of the diagnosis, which may include, but is not limited to the following conditions: a) Familial hyperchylomicronemia or Buerger-Gruetz Syndrome, b) Familial Combined Hyperlipidemia, c) Familial dysbetalipoproteinemia, d) Familial Triglyceridemia, OR e) Endogenous Hypertriglyceridemia.

Products Affected

- PEMAZYRE 13.5MG TAB (New Starts Only)
- PEMAZYRE 4.5MG TAB (New Starts Only)
- PEMAZYRE 9MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of FGFR2 fusion or other rearrangement, as detected by an FDA-approved test
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- PIQRAY 200MG DAILY DOSE PACK (New Starts Only)
- PIQRAY 250MG DAILY DOSE PACK (New Starts Only)
- PIQRAY 300MG DAILY DOSE 150MG PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of PIK3CA-mutation, by an FDA approved test.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- POMALYST 1MG CAP (New Starts Only)
- POMALYST 2MG CAP (New Starts Only)
- POMALYST 3MG CAP (New Starts Only)
- POMALYST 4MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- PREVYMIS 240MG TAB
- PREVYMIS 480MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member will/has initiated Prevymis within 30 days after an allogeneic hematopoietic stem cell transplant.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist, oncologist, transplant or infectious disease specialist.
Coverage Duration	Approved for 4 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CRINONE 4% VAGINAL GEL
- CRINONE 8% VAGINAL GEL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– PROLIA 60MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For osteoporosis: Trial of an oral bisphosphonate was not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- PROMACTA 12.5MG POWDER FOR ORAL SUSP
- PROMACTA 25MG POWDER FOR ORAL SUSP
- PROMACTA 50MG TAB
- PROMACTA 12.5MG TAB
- PROMACTA 25MG TAB
- PROMACTA 75MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- QBRELIS 1MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is unable to swallow solid dosage forms of lisinopril.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– QINLOCK 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– *quinine sulfate 324mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- RAVICTI 1.1GM/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires trial of sodium phenylbutyrate powder.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a metabolic physician or medical geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- RELISTOR 12MG/0.6ML INJ
- RELISTOR 12MG/0.6ML SYRINGE
- RELISTOR 8MG/0.4ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the treatment of opioid-induced constipation (OIC) in adults with advanced illness who are receiving palliative care when response to laxative therapy has not been sufficient: member must have tried and failed lactulose.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 4 months, subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- RETEVMO 40MG CAP (New Starts Only)
- RETEVMO 80MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of RET mutation or RET gene fusion.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– *sildenafil 20mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist or cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- REVLIMID 10MG CAP (New Starts Only)
- REVLIMID 15MG CAP (New Starts Only)
- REVLIMID 2.5MG CAP (New Starts Only)
- REVLIMID 20MG CAP (New Starts Only)
- REVLIMID 25MG CAP (New Starts Only)
- REVLIMID 5MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- REXULTI 0.25MG TAB (New Starts Only)
- REXULTI 0.5MG TAB (New Starts Only)
- REXULTI 1MG TAB (New Starts Only)
- REXULTI 2MG TAB (New Starts Only)
- REXULTI 3MG TAB (New Starts Only)
- REXULTI 4MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For schizophrenia, member has tried and failed 2 of the following: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone OR e) ziprasidone. For Major Depressive Disorder: member has tried and failed, or was intolerant to aripiprazole.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- REYVOW 100MG TAB
- REYVOW 50MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trials of 2 different triptans were ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– RINVOQ 15MG ER TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Failure of, or intolerance to, therapy with methotrexate at a dose of at least 20mg/week (or maximally tolerated dose).
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis: Prescribed by, or in consultation with, a rheumatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ROZLYTREK 100MG CAP (New Starts Only)
- ROZLYTREK 200MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of an FDA-approved test, showing one of the following: a) ROS1 rearrangement OR b) NTRK gene fusion mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- RUBRACA 200MG TAB (New Starts Only)
- RUBRACA 250MG TAB (New Starts Only)
- RUBRACA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- RUZURGI 10MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) confirmed by one of the following: a) Presence of voltage-gated calcium channel antibodies OR b) electrophysiologic compound muscle action potential test findings are consistent with LEMS.

Products Affected

- RYDAPT 25MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *vigabatrin 500mg powder for oral soln (New Starts Only)*
- *vigabatrin 500mg tab (New Starts Only)*
- *vigadrone 500mg powder for oral soln (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *asenapine 10mg sl tab (New Starts Only)*
- *asenapine 2.5mg sl tab (New Starts Only)*
- *asenapine 5mg sl tab (New Starts Only)*
- SECUADO 3.8MG/24HR PATCH (New Starts Only)
- SECUADO 5.7MG/24HR PATCH (New Starts Only)
- SECUADO 7.6MG/24HR PATCH (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has tried and failed 2 of the following: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone OR e) ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SIGNIFOR 0.3MG/ML INJ
- SIGNIFOR 0.6MG/ML INJ
- SIGNIFOR 0.9MG/ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SIMPONI 100MG/ML AUTO-INJECTOR
- SIMPONI 50MG/0.5ML AUTO-INJECTOR
- SIMPONI 100MG/ML SYRINGE
- SIMPONI 50MG/0.5ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Rheumatoid Arthritis (RA): Intolerance to, or failure of, therapy with 2 of the following: a) Humira, b) Enbrel, c) Rinvoq OR d) Xeljanz. For Ankylosing Spondylitis (AS): Intolerance to, or failure of, therapy with 2 of the following: a) Humira, b) Enbrel OR c) Taltz. For Psoriatic Arthritis: Intolerance to, or failure of, therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Stelara, e) Otezla OR f) Xeljanz. For Ulcerative Colitis: Intolerance to, or failure of, therapy with two of the following: a) Humira, b) Stelara OR c) Xeljanz.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For ulcerative colitis : Prescribed by, or in consultation with, a gastroenterology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SIRTURO 100MG TAB
- SIRTURO 20MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SIVEXTRO 200MG INJ
- SIVEXTRO 200MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SKYRIZI 150MG DOSE PACK 75MG/0.83ML
- SKYRIZI 150MG/ML AUTO-INJECTOR
- SKYRIZI 150MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis: Failure of, or intolerance to, therapy with one of the following is required: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) soriatane.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a dermatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– *diclofenac sodium 3% gel*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SOLIQUA 100UNIT-0.033MG/ML PEN INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	One of the following: A) Member is unable to achieve an A1c of 7 or under after three (3) months of treatment with one of the following: i) a maximally dosed GLP-1 receptor agonist OR ii) basal insulin greater than or equal to thirty (30) units per day: OR B) member is currently using both basal insulin AND a GLP-1 receptor agonist.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SOLTAMOX 10MG/5ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SOMAVERT 10MG INJ
- SOMAVERT 15MG INJ
- SOMAVERT 20MG INJ
- SOMAVERT 25MG INJ
- SOMAVERT 30MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SPRITAM 1000MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 250MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 500MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 750MG TAB FOR ORAL SUSP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of, or contraindication to, generic levetiracetam.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SPRYCEL 100MG TAB (New Starts Only)
- SPRYCEL 140MG TAB (New Starts Only)
- SPRYCEL 20MG TAB (New Starts Only)
- SPRYCEL 50MG TAB (New Starts Only)
- SPRYCEL 70MG TAB (New Starts Only)
- SPRYCEL 80MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- STELARA 45MG/0.5ML INJ
- STELARA 45MG/0.5ML SYRINGE
- STELARA 90MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Plaque Psoriasis: Failure of, or intolerance to, therapy with one of the following required: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) soriatane. For Psoriatic Arthritis: Failure of, or intolerance to, one of the following required: a) methothrexate OR b) sulfasalazine. (Trial of methotrexate or sulfasalazine not required for AS with predominant axial involvement). For Ulcerative Colitis and Crohn's Disease: Failure of, or intolerance to, one of the following required: a) corticosteroid, b) azathioprine, c) methotrexate OR d) 6-mercaptopurine..
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's Disease and Ulcerative colitis: Prescribed by, or in consultation with, a gastroenterology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– STIVARGA 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SUCRAID 8500UNIT/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SUNOSI 150MG TAB
- SUNOSI 75MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Failure of, or intolerance to, one of the following: a) modafinil OR b) armodafinil.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep medicine physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis.

Products Affected

- *sunitinib 12.5mg cap (New Starts Only)*
- *sunitinib 25mg cap (New Starts Only)*
- *sunitinib 37.5mg cap (New Starts Only)*
- *sunitinib 50mg cap (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SYMDEKO 50-75MG/75MG PACK
- SYMDEKO TAB 4-WEEK PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SYMPROIC 0.2MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– *trientine 250mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TABRECTA 150MG TAB (New Starts Only)
- TABRECTA 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of MET exo 14 skipping mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TAFINLAR 50MG CAP (New Starts Only)
- TAFINLAR 75MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TAGRISSO 40MG TAB (New Starts Only)
- TAGRISSO 80MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TALTZ 80MG/ML AUTO-INJECTOR
- TALTZ 80MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Plaque Psoriasis: Requires failure of, or intolerance to therapy with, one of the following: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) soriatane. For Ankylosing Spondylitis (AS): Requires failure of, or intolerance to sulfasalazine. (Trial of sulfasalazine not required for AS with predominant axial involvement). For Psoriatic Arthritis: Requires failure of, or intolerance to, one of the following: a) methotrexate OR b) sulfasalazine. For Non-radiographic axial spondyloarthritis: Intolerance or failure of therapy with two non-steroidal anti-inflammatory drugs (NSAIDs).
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis, Non-radiographic axial spondyloarthritis and Ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in cosultation with, a dermatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TALZENNA 0.25MG CAP (New Starts Only)
- TALZENNA 1MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *erlotinib 100mg tab (New Starts Only)*
- *erlotinib 150mg tab (New Starts Only)*
- *erlotinib 25mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *bexarotene 75mg cap (New Starts Only)*
- TARGRETIN 1% GEL (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TASIGNA 150MG CAP (New Starts Only)
- TASIGNA 200MG CAP (New Starts Only)
- TASIGNA 50MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TAVALISSE 100MG TAB
- TAVALISSE 150MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TAZVERIK 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TEGSEDI 284MG/1.5ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by a neurologist, cardiologist, hematologist, or other specialist experienced in the diagnosis and treatment of hereditary transthyretin-mediated amyloidosis.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Hereditary transthyretin-mediated amyloidosis confirmed by genetic sequencing AND amyloidosis confirmed by positive tissue biopsy or laser capture tandem mass spectrometry.

Products Affected

– TEPMETKO 225MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of MET exon 14 skipping mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ANDRODERM 2MG/24HR PATCH
- *testosterone 1% (25mg) gel packet*
- *testosterone 1.62% (1.25gm) gel packet*
- TESTOSTERONE 12.5MG/ACT GEL PUMP
- *testosterone 30mg/act topical soln*
- ANDRODERM 4MG/24HR PATCH
- *testosterone 1% (50mg) gel packet*
- *testosterone 1.62% (2.5gm) gel packet*
- *testosterone 20.25mg/act gel pump*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) For new patients: documentation is provided of morning testosterone levels, from two separate days, that fall below the normal range for a healthy adult male. B) For patients already on testosterone replacement therapy: documentation is provided of at least one morning testosterone level from the last 12 months is required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *tetrabenazine 12.5mg tab*
- *tetrabenazine 25mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- THALOMID 100MG CAP (New Starts Only)
- THALOMID 150MG CAP (New Starts Only)
- THALOMID 200MG CAP (New Starts Only)
- THALOMID 50MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or infectious disease specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TIBSOVO 250MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of IDH1 mutation as detected by an FDA approved test.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– *tobramycin 60mg/ml inh soln*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease physician or pulmonology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- *bosentan 125mg tab*
- *bosentan 62.5mg tab*
- TRACLEER 32MG TAB FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist or cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TREMFYA 100MG/ML AUTO-INJECTOR
- TREMFYA 100MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis: Intolerance to, or failure of, therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Skyrizi, e) Stelara OR f) Otezla. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Stelara e) Otezla OR f) Xeljanz
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis: Prescribed by, or in consultation, with a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TRIKAFTA 100-50-75MG/150MG PACK
- TRIKAFTA 50-25-37.5MG/50MG PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- QUDEXY 100MG ER CAP (New Starts Only)
- QUDEXY 150MG ER CAP (New Starts Only)
- QUDEXY 200MG ER CAP (New Starts Only)
- QUDEXY 25MG ER CAP (New Starts Only)
- QUDEXY 50MG ER CAP (New Starts Only)
- TOPIRAMATE 100MG ER CAP (New Starts Only)
- TOPIRAMATE 150MG ER CAP (New Starts Only)
- TOPIRAMATE 200MG ER CAP (New Starts Only)
- TOPIRAMATE 25MG ER CAP (New Starts Only)
- TOPIRAMATE 50MG ER CAP (New Starts Only)
- TROKENDI 100MG ER CAP (New Starts Only)
- TROKENDI 200MG ER CAP (New Starts Only)
- TROKENDI 25MG ER CAP (New Starts Only)
- TROKENDI 50MG ER CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TRULANCE 3MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TUKYSA 150MG TAB (New Starts Only)
- TUKYSA 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TURALIO 200MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– *lapatinib 250mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- UBRELVY 100MG TAB
- UBRELVY 50MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trials of 2 different triptans were ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *budesonide 9mg er tab*
- UCERIS 2MG/ACT RECTAL FOAM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial and failure, or intolerance to mesalamine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- UKONIQ 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- UPTRAVI 1000MCG TAB
- UPTRAVI 1200MCG TAB
- UPTRAVI 1400MCG TAB
- UPTRAVI 1600MCG TAB
- UPTRAVI 200MCG TAB
- UPTRAVI 400MCG TAB
- UPTRAVI 600MCG TAB
- UPTRAVI 800MCG TAB
- UPTRAVI TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist or cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– VALCHLOR 0.016% GEL (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has received prior skin-directed therapy such as topical steroids.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VELTASSA 16.8GM POWDER FOR ORAL SUSP
- VELTASSA 25.2GM POWDER FOR ORAL SUSP
- VELTASSA 8.4GM POWDER FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has baseline persistent potassium level greater than 5.0 mmol/L.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist, cardiologist, or endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VENCLEXTA 100MG TAB (New Starts Only)
- VENCLEXTA 10MG TAB (New Starts Only)
- VENCLEXTA 50MG TAB (New Starts Only)
- VENCLEXTA STARTING PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VENTAVIS 10MCG/ML INH SOLN
- VENTAVIS 20MCG/ML INH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist or cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- VERQUVO 10MG TAB
- VERQUVO 2.5MG TAB
- VERQUVO 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a cardiology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VERZENIO 100MG TAB (New Starts Only)
- VERZENIO 150MG TAB (New Starts Only)
- VERZENIO 200MG TAB (New Starts Only)
- VERZENIO 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VIBERZI 100MG TAB
- VIBERZI 75MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VITRAKVI 100MG CAP (New Starts Only)
- VITRAKVI 25MG CAP (New Starts Only)
- VITRAKVI 20MG/ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of NTRK gene fusion mutation, as detected by an FDA approved test.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VIZIMPRO 15MG TAB (New Starts Only)
- VIZIMPRO 30MG TAB (New Starts Only)
- VIZIMPRO 45MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *voriconazole 200mg inj*
- *voriconazole 40mg/ml susp*
- *voriconazole 200mg tab*
- *voriconazole 50mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease physician or oncologist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VOSEVI 400-100-100MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer is provided 3) Documentation is provided that member does or does not have cirrhosis 4) Previous Hepatitis C Treatment(s) is provided.
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease specialist or transplant specialist.
Coverage Duration	Coverage duration of 12 weeks.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected

– VOTRIENT 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VRAYLAR 1.5/3MG MIXED PACK (New Starts Only)
- VRAYLAR 3MG CAP (New Starts Only)
- VRAYLAR 6MG CAP (New Starts Only)
- VRAYLAR 1.5MG CAP (New Starts Only)
- VRAYLAR 4.5MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed 2 of the following: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone OR e) ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VYNDAMAX 61MG CAP
- VYNDAQEL 20MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) Diagnosis confirmed by one of the following: i) cardiac biopsy with positive congo red staining and ATTR confirmation by mass spectrometry or immunofluorescence staining ii) Myocardial uptake of Tc-PYP demonstrated by a greater than 1.5 heart-to-contralateral ratio or grade 2 or greater visual evidence B) Absence of light-chain or other forms of amyloidosis confirmed by all of the following: i) Serum kappa/lambda free light chain ratio 0.26 to 1.65 ii) Absence of monoclonal protein via serum protein immunofixation iii) Absence of monoclonal protein via urine protein immunofixation.
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with, a cardiologist or other provider experienced in the treatment of cardiomyopathy of transthyretin-mediated amyloidosis.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- WAKIX 17.8MG TAB
- WAKIX 4.45MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy: failure of, or intolerance to, both of the following: a) Sunosi AND b) either modafinil or armodafinil. For cataplexy, trial of other agents not required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep medicine physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For narcolepsy: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

Products Affected

- XALKORI 200MG CAP (New Starts Only)
- XALKORI 250MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XATMEP 2.5MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For polyarticular juvenile idiopathic arthritis: patient must have trial of, or inability to use, oral methotrexate tablet. For acute lymphoblastic leukemia: trial of oral methotrexate tablet is not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- XELJANZ 10MG TAB
- XELJANZ 5MG TAB
- XELJANZ XR 22MG TAB
- XELJANZ 1MG/ML ORAL SOLN
- XELJANZ XR 11MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 20mg/week required (or maximally tolerated dose). For Juvenile Idiopathic Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose). For Psoriatic Arthritis: Failure of, or intolerance to one of the following: a) methothrexate OR b) sulfasalazine. For Ulcerative Colitis: Failure of, or intolerance to one of the following: a) corticosteroid, b) azathioprine, c) methotrexate OR d) 6-mercaptopurine.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Juvenile idiopathic arthritis or Psoriatic Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist. For Ulcerative Colitis : Prescribed by, or in consultation with a Gastroenterology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XENLETA 600MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for 1 month subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- XGEVA 120MG/1.7ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XIFAXAN 550MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For diagnosis of IBS-D, approval will increase quantity limit to 42 tablets over 14 days, maximum of three fills per contract year.

Products Affected

- XOLAIR 150MG INJ
- XOLAIR 150MG/ML SYRINGE
- XOLAIR 75MG/0.5ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe persistent asthma: There must be: A) Objective evidence of reversible airway obstruction B) Member lgE level must be provided and be between 30 IU/ml and 700 IU/ml (OR between 30 IU/mL and 1300 IU/mL for members aged 6 to 12 years) C) Member must have a positive skin test or RAST test for specific allergic sensitivity D) One of the following: i) Inadequately controlled asthma despite medium dose of inhaled corticosteroids for at least 3 months in combination with a trial of long-acting inhaled beta-agonists or a leukotriene modifier OR ii) systemic steroids or high dose inhaled corticosteroids are required to maintain adequate asthma control. For chronic idiopathic urticaria: one of the following: a) patient remains symptomatic despite H1 antihistamine treatment OR b) has intolerance or contraindication to H1 antihistamine treatment.
Age Restrictions	If for moderate to severe persistent asthma, patient must be at least 6 years old. If for chronic idiopathic urticaria, patient must be at least 12 years old.
Prescriber Restriction	Prescribed by, or in consultation with, an allergy specialist, pulmonary specialist, dermatology specialist, otolaryngologist, or immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XOSPATA 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of FLT3 mutation, by an FDA-approved test required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- XPOVIO 100MG ONCE WEEKLY CARTON (8-PACK) (New Starts On
- XPOVIO 40MG TWICE WEEKLY CARTON (8-PACK) (New Starts On
- XPOVIO 60MG TWICE WEEKLY PACK (New Starts Only)
- XPOVIO 80MG ONCE WEEKLY CARTON (8-PACK) (New Starts Only
- XPOVIO 40MG ONCE WEEKLY CARTON (4-PACK) (New Starts Only
- XPOVIO 60MG ONCE WEEKLY CARTON (4-PACK) (New Starts Only
- XPOVIO 80 MG TWICE WEEKLY (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of prior therapies required. For multiple myeloma: If used in combination with bortezomib and dexamethasone, trial of at least one prior therapy. If used in combination with dexamethasone alone, prior therapies include at least 4 therapies, including at least 2 proteasome inhibitors, 2 immunomodulatory agents and an anti-CD38 monoclonal antibody. For diffuse large B-cell lymphoma: Trial of at least 2 lines of prior systemic therapy.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XTANDI 40MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic castration-resistant prostate cancer (mCRPC) and metastatic castration-sensitive prostate cancer (mCSPC): failure of, intolerance or contraindication to, abiraterone (Zytiga equivalent) required. For nonmetastatic castration-resistant prostate cancer (nmCRPC): failure of, or intolerance to, both of the following: a) Nubeqa and b) Erleada.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- XULTOPHY 100UNIT-3.6MG/ML PEN INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	One of the following: A) Member is unable to achieve an A1c of 7 or under after three (3) months of treatment with one of the following: i) a maximally dosed GLP-1 receptor agonist OR ii) basal insulin greater than or equal to thirty (30) units per day: OR B) member is currently using both basal insulin AND a GLP-1 receptor agonist.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- XYREM 500MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy: failure of, or intolerance to, both of the following: a) Sunosi AND b) either modafinil or armodafinil. For cataplexy, trial of other agents not required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep medicine physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For narcolepsy: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

Products Affected

– *miglustat 100mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a medical geneticist, hematologist, or metabolic physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZEJULA 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZELBORAF 240MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ZEPOSIA 0.92MG CAP (New Starts Only)
- ZEPOSIA 7-DAY STARTER PACK (New Starts Only)
- ZEPOSIA STARTER KIT PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Ulcerative Colitis: Intolerance to, or failure of, therapy with both of the following: a) Humira AND b) Stelara.
Age Restrictions	
Prescriber Restriction	For multiple sclerosis: Prescribed by, or in consultation with, a neurology specialist. For ulcerative colitis : Prescribed by, or in consultation with, a gastroenterology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZOLINZA 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ZYDELIG 100MG TAB (New Starts Only)
- ZYDELIG 150MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZYKADIA 150MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	