Dean Advantage
Prevea360 Medicare Advantage

Medicare Coverage from Dean Health Plan

# Dean Health Plan 2022 Prior Authorization (PA) Criteria

**Please read: This document contains information about our Prior Authorization Criteria**

**Prior Authorization**: Dean Health Plan requires you (or your physician) to get prior authorization for certain drugs. This means that you will need to get approval from Dean Health Plan before you fill your prescriptions. If you don't get approval, Dean Health Plan may not cover the drug.

This document was updated on **12/01/2022**.
For more recent information or other questions, please contact Dean Health Plan, Inc. at **1-877-232-7566 (TTY: 711)**, 8 am – 8 pm, weekdays (year-round) and weekends (Oct. 1 – Mar. 31), or visit **exploreyouradvantage.com**

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# Dean Advantage Medicare Part D Plan

Prior Authorization Criteria
*Last Updated* 12/1/2022

## Products Affected

- *adapalene 0.1% cream*
- *adapalene/benzoyl peroxide 0.1-2.5% gel*
- *tretinoin 0.025% cream*
- *tretinoin 0.05% cream*
- *tretinoin 0.1% cream*
- *adapalene 0.3% gel*
- *tretinoin 0.01% gel*
- *tretinoin 0.025% gel*
- *tretinoin 0.05% gel*
- *tretinoin 0.1% 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. |
| 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. D) For systemic sclerosis-associated interstitial lung disease: a) Diagnosis is confirmed with documentation provided of both of the following: i) HRCT scan AND ii) pulmonary function tests AND b) Member has trial and failed mycophenolate. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a rheumatology specialist or pulmonologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| Other Criteria | |

## Products Affected

– ADBRY 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 Atopic Dermatitis (initial requests): 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 Atopic Dermatitis (continuation requests): Prescriber attests to improvement in the member's condition with use of the medication. |
| Age Restrictions | |
| Prescriber Restriction | For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | For atopic dermatitis (initial requests): 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. |

## 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. |
| 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. |
| 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. |
| 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 | For initial requests: 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 | |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## 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 | Documentation is provided of ALK-positive disease. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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 or tinidizole is required. For diarrhea due to cryptosporidiosis, trial of metronidazole or tinidizole NOT required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

- ARALAST 1000MG INJ
- PROLASTIN 1000MG INJ
- GLASSIA 1000MG/50ML INJ
- ZEMAIRA 1000MG INJ

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | IgA deficiency with known anti-IgA antibody. |
| Required Medical Info | Diagnosis of congenital alpha1-antitrypsin deficiency is confirmed by both of the following: a) circulating baseline alpha1-antitrysin level is below the standard protective threshold (less than 11 micromol/L OR less than 50 mg per deciliter by nephelometry) AND b) high risk alpha1-antitrypsin deficiency genotype (SS, SZ, ZZ, or null/null) |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a pulmonologist |
| Coverage Duration | Approved for duration of contract year. |
| 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 | Documentation is provided of ALK-positive disease. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| Other Criteria | |

## Products Affected

- 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/ML INJ
- ARANESP 60MCG/0.3ML SYRINGE
- ARANESP 100MCG/ML INJ
- ARANESP 150MCG/0.3ML SYRINGE
- ARANESP 200MCG/ML INJ
- ARANESP 25MCG/ML INJ
- ARANESP 40MCG/0.4ML SYRINGE
- ARANESP 500MCG/ML SYRINGE
- ARANESP 60MCG/ML INJ

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of Retacrit or Epogen was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of contract year. |
| 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 | For Cryopyrin-Associated Periodic Syndromes (CAPS) (including Familial Cold Auto-inflammatory Syndrome [FCAS], and Muckle-Wells Syndrome [MWS]): Prescribed by, or in consultation with, a dermatologist, immunologist, rheumatologist, or pediatrician. For deficiency of interleukin-1 receptor antagonist (DIRA): Prescribed by, or in consultation with, a provider specializing in the treatment of DIRA. For Recurrent Pericarditis (RP): Prescribed by, or in consultation with, a cardiologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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. |
| 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. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

- *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. |
| 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 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. |
| Other Criteria | Will not be used in combination with voclosporin (Lupkynis). For lupus erythematosus initial therapy: Diagnosis of active systemic lupus erythematosus is confirmed by one of the following: A) anti-double stranded DNA value greater than 30 IU/mL OR B) low complement (C3/C4). For lupus erythematosus continuation therapy: lab values not required. For active lupus nephritis: 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. |
| Other Criteria | |

## Products Affected

– BESREMI 500MCG/ML SYRINGE (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. |
| 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. |
| 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 | Documentation is provided of appropriate BRAF V600E or V600K mutation. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

- BYLVAY 1200MCG CAP
- BYLVAY 200MCG ORAL PELLET
- BYLVAY 400MCG CAP

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | a)Diagnosis of progressive familial intrahepatic cholestasis confirmed by genetic testing (documentation is provided) AND<br>b)Genetic testing does not indicate presence of ABCB11 variants that result in non-functional or complete absence of the BSEP-3 protein. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a hepatologist, gastroenterologist, or provider that specializes in progressive familial intrahepatic cholestasis. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

- *calcipotriene 0.005% cream*
- *calcipotriene 0.005% ointment*
- *calcipotriene 0.005% topical 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. |
| Other Criteria | |

## Products Affected

- CALQUENCE 100MG CAP (New Starts Only)
- CALQUENCE 100MG 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. |
| Other Criteria | |

## Products Affected

- CAPLYTA 10.5MG CAP (New Starts Only)
- CAPLYTA 21MG CAP (New Starts Only)
- 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. |
| 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. |
| 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. |
| 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. |
| 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

- CIBINQO 100MG TAB
- CIBINQO 200MG TAB
- CIBINQO 50MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For Atopic Dermatitis (initial requests): 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 Atopic Dermatitis (continuation requests): Prescriber attests to improvement in the member's condition with use of the medication. |
| Age Restrictions | |
| Prescriber Restriction | For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | For atopic dermatitis (initial requests): 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. |

## 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, c) Taltz, d) Rinvoq, OR e) 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, f) Skyrizi, g) Rinvoq OR h) 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 2 of the following: a) Humira, b) Stelara, OR c) Skyrizi. 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. |
| Other Criteria | |

## Products Affected

- COMETRIQ CAP 100MG DAILY DOSE CARTON PACK (New Starts O
- COMETRIQ CAP 140MG DAILY DOSE CARTON PACK (New Starts O
- COMETRIQ CAP 60MG DAILY DOSE CARTON PACK (New Starts On

| 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. |
| 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. |
| 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 | For adults (18 years and older), 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. |
| 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 | Documentation is provided of appropriate BRAF V600E or V600K mutation. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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 | Trial of at least 1 anti-epileptic medication was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

– DIFICID 200MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of, intolerance, or contraindication to generic vancomycin capsules. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for 1 month. |
| Other Criteria | |

## Products Affected

– DOPTELET 20MG TAB

| 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. |
| Other Criteria | |

## Products Affected

- DAYVIGO 10MG TAB
- DAYVIGO 5MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial and failure of two of the following: a) eszopiclone, b) ramelteon, c) zaleplon, or d) zolpidem. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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 100MG/0.67ML SYRINGE
- DUPIXENT 200MG/1.14ML SYRINGE
- DUPIXENT 300MG/2ML SYRINGE
- DUPIXENT 200MG/1.14ML AUTO-INJECTOR
- DUPIXENT 300MG/2ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: 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 (trial of other agents not required for patients under 2 years of age). 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 eosinophilic esophagitis: Trial of a topical corticosteroid was ineffective, not tolerated, or contraindicated. 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 months of age or older. For Asthma: Member must be 6 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, gastroenterologist, immunologist, pulmonologist, dermatologist or ENT specialist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | For initial requests: 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). For eosinophilic esophagitis, both of the following: A) endoscopic biopsy with at least 15 eosinophils per high-power field (hpf) AND B) symptoms of esophageal dysfunction (e.g. dysphagia). |

## 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 | For initial requests: 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 | |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

- 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. |
| 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. |
| 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. |
| 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 3 years of age or older |
| 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. |
| Other Criteria | |

## Products Affected

- EPOGEN 10000UNIT/ML INJ
- EPOGEN 20000UNIT/ML INJ
- EPOGEN 2000UNIT/ML INJ
- EPOGEN 3000UNIT/ML INJ
- EPOGEN 4000UNIT/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 | |
| Coverage Duration | Approved for duration of contract year. |
| 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 | |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist or dermatologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| Other Criteria | |

## Products Affected

- ESBRIET 267MG CAP
- ESBRIET 267MG TAB
- ESBRIET 801MG TAB
- *pirfenidone 267mg tab*
- *pirfenidone 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. |
| 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. |
| Other Criteria | Will not be used in combination with nusinersen (Spinraza). |

## Products Affected

– EXKIVITY 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 | Documentation is provided of EGFR exon 20 insertion mutation. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## 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. |
| 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 | For initial requests: 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). For continuation requests: Documentation is provided of positive clinical response. |
| 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. |
| Other Criteria | |

## Products Affected

- *deferiprone 1000mg tab*
- *deferiprone 500mg tab*
- FERRIPROX 1000MG 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. |
| 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. |
| Other Criteria | |

## Products Affected

– FIRDAPSE 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. |
| 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

- FIRMAGON 120MG/VIAL 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. |
| Other Criteria | |

## Products Affected

– DICLOFENAC EPOLAMINE 1.3% PATCH

| 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| 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 | Documentation is provided of appropriate EGFR mutation. For squamous non-small cell lung cancer, documentation of EGFR mutation not required. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| Other Criteria | |

## Products Affected

- BERINERT 500UNIT INJ
- HAEGARDA 3000UNIT INJ
- *sajazir 30mg/3ml syringe*
- TAKHZYRO 300MG/2ML SYRINGE
- HAEGARDA 2000UNIT INJ
- *icatibant 10mg/ml syringe*
- 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. |
| Other Criteria | |

## Products Affected

- HETLIOZ 20MG CAP
- HETLIOZ 4MG/ML SUSP

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For non-24-hour sleep-wake disorder: Member is totally blind. For Smith-Magenis syndrome: Diagnosis of nighttime sleep disturbances in Smith-Magenis syndrome. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist or sleep specialist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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 SYRINGE (2) 40MC
- 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
- HUMIRA PEN 80MG/0.8ML AND 40MG/0.4ML - PSORIASIS/UVEITI
- HUMIRA PREFILLED SYRINGE 80MG/0.8ML STARTER PACK - PEI

| 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, therapy 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. |
| | |

| | |
|---|---|
| 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. |
| 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. |
| 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. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist or hematologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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)
- IMBRUVICA 70MG/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 | |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist, hemotologist, or transplant specialist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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 OR iii) Member has symptoms of tardive dyskinesia and is not using 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. |
| 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. |
| 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. |
| 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. |
| 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 | Documentation is provided of appropriate EGFR mutation. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| Other Criteria | |

## Products Affected

– *itraconazole 10mg/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 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
- 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
- FLEBOGAMMA 5GM/50ML 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

| 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. |
| 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, oncologist, or transplant specialist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| Other Criteria | |

## Products Affected

- KERENDIA 10MG TAB
- KERENDIA 20MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of Farxiga was not tolerated or contraindicated. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

- *javygtor 100mg powder for oral soln*
- *sapropterin 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 continuation therapy: Documentation is provided of disease improvement. |
| 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

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

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Member has failed levodopa/carbidopa adjunctive therapy in combination with both of the following: a) rasagiline AND b) entacapone. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

– LIVMARLI 9.5MG/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 initial requests: Documentation is provided of a mutation in one of the following: a) JAG1 gene OR b) NOTCH2 gene.<br>For continuation requests: Prescriber attests to improvement in the member's condition with use of the medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a hepatologist, gastroenterologist, or provider that specializes in the treatment of Alagille syndrome. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

– LIVTENCITY 200MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Prescriber attests that the medication will not be used for CMV infection prophylaxis. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a hematologist, oncologist, transplant or infectious disease specialist. |
| Coverage Duration | Approved for 3 months. |
| 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. |
| 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. |
| 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 | Documentation is provided of ALK-positive disease. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

– LUCEMYRA 0.18MG 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, clonidine. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a prescriber specializing in pain management or addiction treatment. |
| Coverage Duration | Approved for 1 month. |
| Other Criteria | If member was initiated on lofexidine at an inpatient facility and request is for continuing therapy for up to a total of 14 days, prescriber and medical restrictions not required. |

## 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. |
| 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. |
| Other Criteria | Will not be used in combination with belimumab (Benlysta). |

## Products Affected

- LYBALVI 10-10MG TAB (New Starts Only)
- LYBALVI 15-10MG TAB (New Starts Only)
- LYBALVI 20-10MG TAB (New Starts Only)
- LYBALVI 5-10MG 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 | 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. |
| Other Criteria | |

## 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. |
| Other Criteria | |

## Products Affected

- MAVYRET 100-40MG TAB
- MAVYRET 50-20MG ORAL PELLET

| 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 3 years of age or older |
| 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. |
| 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. |
| 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 | Documentation is provided of appropriate BRAF V600E or V600K mutation. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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 | Documentation is provided of appropriate BRAF V600E or V600K mutation. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

– METHYLTESTOSTERONE 10MG CAP

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | A) For hypogonadism: Documentation is provided of morning testosterone levels, from two separate days, 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. C) For sexual development or metastasis from malignant tumor of breast, inoperable metastatic disease (skeletal) in women 1 to 5 years postmenopausal: testosterone levels are not required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

– *dihydroergotamine mesylate 0.5mg/act nasal inhaler*

| 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. |
| Other Criteria | |

## Products Affected

- MOTEGRITY 1MG TAB
- MOTEGRITY 2MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial and failure of trulance. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

- MOUNJARO 10MG/0.5ML AUTO-INJECTOR
- MOUNJARO 12.5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 15MG/0.5ML AUTO-INJECTOR
- MOUNJARO 2.5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 7.5MG/0.5ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of both of the following was ineffective, contraindicated, or not tolerated: A) Trulicity AND B) Ozempic. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| Other Criteria | |

## Products Affected

- MYFEMBREE 1-0.5-40MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Member has failure of, or intolerance to, 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. |
| Other Criteria | Member does not have known osteoporosis. |

## Products Affected

- ABELCET 5MG/ML INJ
- *acetylcysteine 200mg/ml inh soln*
- *albuterol 0.21mg/ml (0.63mg/3ml) inh soln*
- *albuterol 5mg/ml inh soln*
- AMBISOME 50MG INJ
- ANZEMET 50MG TAB
- *aprepitant 125mg/aprepitant 80mg pack*
- *aprepitant 80mg cap*
- ASTAGRAF 0.5MG ER CAP
- ASTAGRAF 5MG ER CAP
- *azathioprine 50mg 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 50mg cap*
- ENGERIX-B 10MCG/0.5ML SYRINGE
- ENGERIX-B 20MCG/ML SYRINGE
- ENVARSUS 1MG ER TAB
- *everolimus 0.25mg tab*
- *everolimus 0.75mg tab*
- FIASP 100UNIT/ML INJ
- *acetylcysteine 100mg/ml inh soln*
- *acyclovir 50mg/ml inj*
- *albuterol 0.83mg/ml (0.083%) inh soln*
- *albuterol neb soln 1.25mg/3ml*
- AMPHOTERICIN B 50MG INJ
- *aprepitant 125mg cap*
- *aprepitant 40mg cap*
- *arformoterol tartrate 15mcg/2ml neb soln*
- ASTAGRAF 1MG ER CAP
- *azathioprine 100mg tab*
- *azathioprine 75mg 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*
- *cyclosporine modified 25mg cap*
- DIPHTHERIA/TETANUS TOXOID INJ
- ENGERIX-B 20MCG/ML INJ
- ENVARSUS 0.75MG ER TAB
- ENVARSUS 4MG ER TAB
- *everolimus 0.5mg tab*
- *everolimus 1mg tab*
- *formoterol fumarate neb soln 20mcg/2ml*

- *gengraf 100mg cap*
- *gengraf 25mg cap*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 2MG/ML INJ
- *granisetron 1mg tab*
- IMOVAX 2.5UNIT/ML INJ
- INTRALIPID 30GM/100ML INJ
- *ipratropium/albuterol 0.5-2.5mg/3ml inh soln*
- *levalbuterol neb soln 0.31mg/3ml*
- *levalbuterol neb soln 1.25mg/3ml*
- *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 4mg odt*
- *ondansetron 8mg odt*
- *pentamidine isethionate 50mg/ml inh soln*
- *prednisolone 1mg/ml oral soln*
- *prednisolone 3mg/ml oral soln*
- PREDNISOLONE 5MG/ML ORAL SOLN
- *prednisone 1mg tab*
- *prednisone 2.5mg tab*
- *prednisone 50mg tab*
- PREDNISONE 5MG/ML ORAL SOLN
- PREMASOL 10% INJ
- PROGRAF 1MG GRANULES FOR ORAL SUSP
- PULMOZYME 1MG/ML INH SOLN
- RECOMBIVAX 10MCG/ML INJ
- RECOMBIVAX 40MCG/ML INJ
- *gengraf 100mg/ml oral soln*
- *glucose 100mg/ml inj*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 4.5MG/ML INJ
- HUMULIN R 500UNIT/ML INJ
- INTRALIPID 20GM/100ML INJ
- *ipratropium bromide 0.2mg/ml inh soln*
- *levalbuterol 0.21mg/ml inh soln*
- *levalbuterol neb soln 1.25mg/0.5ml*
- 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 tab*
- *ondansetron 8mg tab*
- *plenamine 15% inj*
- *prednisolone 2mg/ml oral soln*
- *prednisolone 4mg/ml oral soln*
- *prednisone 10mg tab*
- PREDNISONE 1MG/ML ORAL SOLN
- *prednisone 20mg tab*
- *prednisone 5mg tab*
- PREHEVBRIO 10MCG/ML INJ
- PROGRAF 0.2MG GRANULES FOR ORAL SUSP
- PROSOL 20% INJ
- RABAVERT 2.5UNIT/ML INJ
- RECOMBIVAX 10MCG/ML SYRINGE
- RECOMBIVAX 5MCG/0.5ML INJ

- RECOMBIVAX 5MCG/0.5ML SYRINGE
- *sirolimus 0.5mg tab*
- *sirolimus 1mg/ml oral soln*
- *tacrolimus 0.5mg cap*
- *tacrolimus 5mg cap*
- TENIVAC 4-10UNIT/ML INJ
- TPN ELECTROLYTES INJ
- TROPHAMINE 10% INJ
- ZORTRESS 1MG TAB
- SANDIMMUNE 100MG/ML ORAL SOLN
- *sirolimus 1mg tab*
- *sirolimus 2mg tab*
- *tacrolimus 1mg cap*
- TDVAX 4-4UNIT/ML INJ
- TENIVAC 4-10UNIT/ML SYRINGE
- TRAVASOL 10% INJ
- VARUBI 90MG TAB

| 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. |
| 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. |
| Other Criteria | |

## Products Affected

– *sorafenib 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. |
| 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

– *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. |
| 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. |
| Other Criteria | |

## Products Affected

- NUCALA 100MG INJ
- NUCALA 100MG/ML AUTO-INJECTOR
- NUCALA 100MG/ML SYRINGE
- NUCALA 40MG/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 Asthma diagnosis: Both of the following: 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. For hypereosinophilic syndrome: Both of the following: A) Diagnosis confirmed by blood eosinophil count greater than 1000 cells per microliter AND B) Hypereosinophilic syndrome has persisted for at least six months. 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): Documentation is provided of positive clinical response. |
| 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. For hypereosinophilic syndrome diagnosis: Member must be 12 years of age or older. |
| Prescriber Restriction | Prescribed by, or in consultation with, an allergy specialist, immunologist, otolaryngologist, pulmonary specialist, gastroenterologist, hematologist, or rheumatologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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 (in the form of chart notes or imaging) of structural neurological condition as the cause of pseudobulbar affect. For continuation requests, both of the following: A) Documentation is provided (in the form of chart notes or imaging) of structural neurological condition as the cause of pseudobulbar affect AND B) Member has demonstrated improvement while on Nuedexta. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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 | For acute treatment of migraine: Trials of 2 different triptans were ineffective or not tolerated. For migraine prevention: Failure of, or intolerance to, both of the following: A) Emgality AND B) Aimovig. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

- *octreotide 0.05mg/ml inj*
- *octreotide 0.1mg/ml inj*
- *octreotide 0.2mg/ml inj*
- *octreotide 0.5mg/ml inj*
- *octreotide 1mg/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 | |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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 AND 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 AND 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 AND 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. |
| 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. |
| Other Criteria | |

## Products Affected

- ONGENTYS 25MG CAP
- ONGENTYS 50MG CAP

| 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

- *fentanyl 1200mcg lozenge*
- fentanyl 200mcg lozenge
- *fentanyl 600mcg lozenge*
- *fentanyl 1600mcg lozenge*
- *fentanyl 400mcg lozenge*
- *fentanyl 800mcg lozenge*

| 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. |
| 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, f) Skyrizi OR g) Xeljanz. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with a Rheumatology or Transplant Specialist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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, 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. |
| 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. |
| 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. |
| 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. |
| 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: Failure of, or intolerance to, one of the following required: a) methothrexate OR b) sulfasalazine. 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. |
| 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

- *oxandrolone 10mg tab*
- *oxandrolone 2.5mg 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 | |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

- OXBRYTA 300MG TAB FOR ORAL SUSP
- 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. |
| 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. |
| Other Criteria | |

## Products Affected

– PANRETIN 0.1% 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 | |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

- 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. |
| 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. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

- PYRUKYND 20MG TAB (4-WEEK PACK)
- PYRUKYND 50MG TAB (4-WEEK PACK)
- PYRUKYND 5MG TAB TAPER PACK
- PYRUKYND 20MG/50MG TAB TAPER PACK
- PYRUKYND 5MG TAB (4-WEEK PACK)
- PYRUKYND 5MG/20MG TAB TAPER PACK

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: Diagnosis of pyruvate kinase deficiency confirmed by genetic testing (documentation is provided). For continuation requests: Prescriber attests to improvement in the member's condition with use of the medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a hematologist or a specialist in treating pyruvate kinase deficiency. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

– REGRANEX 0.01% 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. |
| 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. |
| Other Criteria | |

## Products Affected

- RETACRIT 10000UNIT/ML INJ
- RETACRIT 20000UNIT/ML INJ
- RETACRIT 3000UNIT/ML INJ
- RETACRIT 4000UNIT/ML INJ
- RETACRIT 20000UNIT/2ML INJ
- RETACRIT 2000UNIT/ML INJ
- RETACRIT 40000UNIT/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 | |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

- *lenalidomide 2.5mg cap (New Starts Only)*
- *lenalidomide 5mg cap (New Starts Only)*
- REVLIMID 15MG CAP (New Starts Only)
- REVLIMID 20MG CAP (New Starts Only)
- REVLIMID 5MG CAP (New Starts Only)
- *lenalidomide 20mg cap (New Starts Only)*
- REVLIMID 10MG CAP (New Starts Only)
- REVLIMID 2.5MG CAP (New Starts Only)
- REVLIMID 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

– REZUROCK 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 oncologist, hematologist, or transplant specialist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

- RINVOQ 15MG ER TAB
- RINVOQ 30MG ER TAB
- RINVOQ 45MG 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 one of the following: a) Humira OR b) Enbrel. For Psoriatic Arthritis: Failure of, or one of the following: a) Humira OR b) Enbrel. For Atopic Dermatitis (initial requests): 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 Atopic Dermatitis (continuation requests): Prescriber attests to improvement in the member's condition with use of Rinvoq. For Ulcerative Colitis: Failure of, or intolerance to Humira. For ankylosing spondylitis: Failure of, or intolerance to therapy with one of the following: a) Humira OR b) Enbrel. |
| Age Restrictions | |
| Prescriber Restriction | For Rheumatoid Arthritis or psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. For ulcerative colitis: Prescribed by, or in consultation with a Gastroenterology Specialist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | For atopic dermatitis (initial requests): 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. |

## 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 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. |
| 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. |
| Other Criteria | |

## 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. |
| 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. |
| Other Criteria | |

## Products Affected

- 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. |
| Other Criteria | |

## Products Affected

- SCEMBLIX 20MG TAB (New Starts Only)
- SCEMBLIX 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 or hematologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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, c) Taltz, d) Rinvoq, OR e) 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, f) Skyrizi, g) Rinvoq, OR h) Xeljanz. For Ulcerative Colitis: Intolerance to, or failure of, therapy with two of the following: a) Humira, b) Stelara, c) Rinvoq, OR d) 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

- SKYRIZI 150MG DOSE PACK 75MG/0.83ML
- SKYRIZI 150MG/ML AUTO-INJECTOR
- SKYRIZI 150MG/ML SYRINGE
- SKYRIZI 360MG/2.4ML CARTRIDGE

| 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. For Psoriatic Arthritis: Failure of, or intolerance to one of the following: a) methothrexate OR b) sulfasalazine. For 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 | Prescribed by, or in consultation with, a dermatology specialist. For Psoriatic Arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's Disease: Prescribed by, or in consultation with, a gastroenterology specialist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| Other Criteria | |

## Products Affected

– SOLIQUA 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. |
| Other Criteria | |

## Products Affected

– SOLOSEC 2GM GRANULES

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For bacterial vaginosis: intolerance to, or failure of, therapy with 2 of the following: a) metronidazole, b) clindamycin OR c) tinidazole. For trichomonas vaginalis: intolerance to, or failure of, therapy with both of the following: a) metronidzazole AND b) tinidazole. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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. |
| 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. |
| 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. 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

– SYNAREL 2MG/ML NASAL INHALER

| 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. |
| Other Criteria | |

## Products Affected

– SYNRIBO 3.5MG 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 hematologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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 exon 14 skipping mutation. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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 | Documentation is provided of appropriate BRAF V600E or V600K mutation. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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 | Documentation is provided of appropriate EGFR mutation. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| Other Criteria | |

## Products Affected

- TALZENNA 0.25MG CAP (New Starts Only)
- TALZENNA 0.5MG CAP (New Starts Only)
- TALZENNA 0.75MG 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. |
| 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 | Documentation is provided of appropriate EGFR mutation. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

- *bexarotene 1% gel (New Starts Only)*
- *bexarotene 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 or dermatologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

– TAVNEOS 10MG CAP

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Member is positive for antibodies to one of the following: a) proteinase 3 OR b) myeloperoxidase. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a rheumatologist or nephrologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

- *tazarotene 0.1% cream*
- TAZORAC 0.05% 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. |
| 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

- *testosterone 1% (12.5mg/act) gel pump*
- *testosterone 1% (25mg) gel packet*
- *testosterone 1% (50mg) gel packet*
- *testosterone 1.62% (1.25gm) gel packet*
- *testosterone 1.62% (2.5gm) gel packet*
- *testosterone 1.62% (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, showing improvement, is required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist or hematologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

- TRIKAFTA 100-50-75MG/150MG PACK
- TRIKAFTA 50-37.5-25MG/75MG TAB 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. |
| Other Criteria | |

## Products Affected

- TRUSELTIQ 100MG DAILY DOSE CARTON (21) (New Starts Only)
- TRUSELTIQ 125MG DAILY DOSE CARTON (42) (New Starts Only)
- TRUSELTIQ 50MG DAILY DOSE CARTON (42) (New Starts Only)
- TRUSELTIQ 75MG DAILY DOSE CARTON (63) (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. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

- TYVASO 16-32-48MCG TITRATION PACK
- TYVASO 16-32MCG TITRATION PACK
- TYVASO 16MCG INH POWDER
- TYVASO 32-48MCG MAINTENANCE PACK
- TYVASO 32MCG INH POWDER
- TYVASO 48MCG INH POWDER
- TYVASO 64MCG INH POWDER

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For all indications: Diagnosis of pulmonary arterial hypertension confirmed by right heart catheterization. For pulmonary arterial hypertension associated with interstitial lung disease (ILD): Interstitial lung disease confirmed by high-resolution computed tomography (HRCT). |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a pulmonologist or cardiologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| 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. |
| 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. |
| 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 | A) 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

- VIJOICE 125MG 28 DAY PACK
- VIJOICE 250MG 28 DAY PACK
- VIJOICE 50MG 28 DAY 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 of mutation in the PIK3CA gene. For continuation requests: Prescriber attests to improvement in the member's condition with use of the medication. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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 | Documentation is provided of appropriate EGFR mutation. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

– VONJO 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. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

- VOXZOGO 0.4MG INJ
- VOXZOGO 0.56MG INJ
- VOXZOGO 1.2MG INJ

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: 1) Documentation is provided of the fibroblast growth factor receptor 3 (FGFR3) gene mutation AND 2) Member has open epiphyses. For continuation requests: 1) Epiphyses remain open AND 2) Prescriber attests to improvement in the member's condition with use of the medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a provider specialized in the treatment of achondroplasia. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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. |
| Other Criteria | |

## Products Affected

– VYZULTA 0.024% OPHTH SOLN

| 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 both: A) latanoprost AND B) one of the following: 1) bimatoprost, travoprost, Lumigan, or Zioptan. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| 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

– WELIREG 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. |
| Other Criteria | |

## 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 | Documentation is provided of ALK-positive or ROS1-positive disease. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| 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. |
| Other Criteria | |

## Products Affected

- XELJANZ 10MG TAB
- XELJANZ 11MG ER TAB
- XELJANZ 1MG/ML ORAL SOLN
- XELJANZ 22MG ER TAB
- XELJANZ 5MG 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 one of the following: a) Humira OR b) Enbrel. For Juvenile Idiopathic Arthritis: Failure of, or intolerance to therapy with one of the following: a) Humira OR b) Enbrel. For Psoriatic Arthritis: Failure of, or one of the following: a) Humira OR b) Enbrel. For ankylosing spondylitis: Failure of, or intolerance to therapy with one of the following: a) Humira OR b) Enbrel. For Ulcerative Colitis: Failure of, or intolerance to Humira. |
| Age Restrictions | |
| Prescriber Restriction | For Rheumatoid Arthritis, Juvenile idiopathic arthritis, ankylosing spondylitis, 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. |
| 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. |
| Other Criteria | |

## Products Affected

- XERMELO 250MG 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 oncologist, endocrinologist, or gastroenterologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | Patient is currently taking somatostatin analog therpy and still experiencing symptoms. |

## 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. |
| 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. |
| 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 initial requests: For moderate to severe persistent asthma: There must be: A) Objective evidence of reversible airway obstruction B) Member must have a positive skin test or RAST test for specific allergic sensitivity C) 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. For nasal polyps: A) Confirmed diagnosis of nasal polyps (see other criteria) AND B) Trial of Dupixent was ineffective, not tolerated, or contraindicated. For continuation requests (all diagnoses): Documentation is provided of positive clinical response. |
| 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. If for nasal polyps, patient must be at least 18 years old. |
| Prescriber Restriction | Prescribed by, or in consultation with, an allergist, pulmonologist, dermatologist, ENT specialist, or immunologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | For nasal polyps (initial requests): Diagnosis is confirmed with a sinus CT scan AND at least four of the following apply: a) prior surgery for bilateral nasal polyposis b) evidence of type 2 inflammation c) two or more courses of oral corticosteroids required in the prior year d) significantly impaired quality of life e) significant loss of smell f) diagnosis of comorbid asthma |

## 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. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist or hematologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

- XPOVIO 100MG ONCE WEEKLY CARTON (8-PACK) (New Starts Onl
- XPOVIO 40MG TWICE WEEKLY CARTON (8-PACK) (New Starts Onl
- 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 | |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist or hematologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

- XTANDI 40MG CAP (New Starts Only)
- XTANDI 40MG TAB (New Starts Only)
- XTANDI 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 | 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. |
| 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. |
| 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 in adults: failure of, or intolerance to, both of the following: a) Sunosi AND b) either modafinil or armodafinil. For cataplexy and patients aged 7 to 17 years: 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. |
| 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. |
| 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. |
| 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 | Documentation is provided of appropriate BRAF V600E or V600 mutation. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

## Products Affected

- ZEPOSIA 0.92MG CAP
- ZEPOSIA 7-DAY STARTER PACK
- ZEPOSIA STARTER KIT PACK

| 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 two of the following: a) Humira, b) Stelara, c) Rinvoq OR d) Xeljanz. |
| 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. |
| 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. |
| 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. |
| 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 | Documentation is provided of ALK-positive disease. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an oncologist. |
| Coverage Duration | Approved for duration of contract year. |
| Other Criteria | |

Dean Medicare Advantage

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Dean Medicare Advantage
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