2021 AmeriHealth Caritas VIP Care Plus

2021 Prior Authorization Criteria

CURRENT AS OF 02/01/2021

acitretin

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For prophylaxis of skin cancer in patients with previously treated skin cancers who have undergone an organ transplantation the request will be approved. For psoriasis: the patient has documented adequate trials and/or has another documented medical reason for not using at least 2 of the treatment options listed: topical steroids, Tazorac (tazarotene), methotrexate, and cyclosporine.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a dermatologist or an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

actemra

Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test) AND 2) Trial of, contraindication to, or medical reason for not using Humira (adalimumab) and Xeljanz or Xeljanz XR (tofacitinib) for appropriate indications.
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

actimmune

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

adefovir

Products Affected

- *adefovir dipivoxil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

adempas

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with PDE inhibitor or nitrate therapy
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group classification. For WHO Group I and IV, documentation of PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using PDE inhibitors or nitrates.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

alpha-1 proteinase inhibitors

Products Affected

- ARALAST NP
- GLASSIA
- PROLASTIN-C
- ZEMAIRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Documentation of hereditary alpha1-antitrypsin deficiency as evident by pretreatment serum AAT levels below 11 micrometer/L and progressive FEV1 or FVC decline demonstrating symptomatic lung disease. AND 2) If the medication request is for an Alpha1-Proteinase Inhibitor (human) product other than Prolastin, the patient has a documented medical reason (such as trial, intolerance or contraindication) for not using Prolastin to treat their medical condition.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ambrisentan

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group classification and PAH Functional Class.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

anadrol

Products Affected

- ANADROL-50

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

apokyn

Products Affected

- APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE

PA Criteria	Criteria Details
Exclusion Criteria	Apokyn (apomorphine hydrochloride) is contraindicated in concomitant use with serotonin 5-HT3 receptor antagonists.
Required Medical Information	Reviewer will verify available patient claim history to confirm patient is not using 5-HT3 receptor antagonists. If diagnosis is Parkinson's, the patient must have a documented trial of, contraindication to, or medical reason for not using two formulary alternatives such as entacapone, tolcapone, rasagiline, selegiline, carbidopa/levodopa, bromocriptine, pramipexole or ropinirole.
Age Restrictions	
Prescriber Restrictions	Documentation of a consultation with a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

arcalyst

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

aripiprazole long acting

Products Affected

- ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE
- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER
- ARISTADA INITIO
- ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML, 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The member has a documented history of receiving oral aripiprazole without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing one of these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ayvakit

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmation of PDGFRA mutation.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

banzel

Products Affected

- BANZEL ORAL SUSPENSION
- BANZEL ORAL TABLET
- *rufinamide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For treatment of Lennox Gastaut Syndrome, patient must have documented trial and failure or intolerance to one formulary anticonvulsant agent that is indicated for Lennox-Gastaut Syndrome.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

benlysta

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation has been provided indicating the patient has had an adequate trial of two or more of the following agents: glucocorticoids, azathioprine, methotrexate, mycophenolate, or hydroxychloroquine.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a rheumatologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

benznidazole

Products Affected

- *benznidazole*

PA Criteria	Criteria Details
Exclusion Criteria	Patients who have used disulfiram within two weeks of initiation of benznidazole
Required Medical Information	Patient has not used disulfiram within two weeks prior to benznidazole initiation per claims history for existing members or attestation from provider for members new to the health plan.
Age Restrictions	
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 60 days.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

botox

Products Affected

- BOTOX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For chronic migraine-initial: 6 months, reauth: contract yr. For all other indications: contract yr.
Other Criteria	For a diagnosis of Achalasia, the patient had trial of or medical reason for not using two formulary calcium channel blockers. For a diagnosis of chronic anal fissure or anal spasm, the patient has been unresponsive to topical anesthetics, steroids or topical nitroglycerin. For a diagnosis of sialorrhea, the patient has been unresponsive to anticholinergic therapy. For a diagnosis of urinary incontinence, the patient had trial of or medical reason not to use two formulary anticholinergics. For a patient newly initiated on Botox for a diagnosis of chronic migraine headache, provider attests that patient has at least 4 migraine days per month or one or more severe migraines lasting for greater than 12 hours despite use of abortive therapy (e.g. triptans or NSAIDs). Patient has trial of or medical reason not to use a calcitonin gene-related peptide (CGRP) receptor antagonists AND at least two of the following agents: an anti-epileptics, a beta-adrenergic blocker, venlafaxine, amitriptyline. For reauthorization for migraine prophylaxis, patient must have experienced reduction of at least 1 headache day per month within the last month of the initial authorization period. For a diagnosis of limb spasticity, the patient must be unresponsive to at least one oral antispasticity drug (such as baclofen, benzodiazepines, dantrolene, etc.)
Indications	All Medically-accepted Indications.
Off Label Uses	

brukinsa

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

budesonide er 9 mg

Products Affected

- *budesonide er oral tablet extended release 24 hour*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 8 weeks.
Other Criteria	Patient must have a documented trial of, contraindication to, or medical reason for not using sulfasalazine, balsalazide, or an oral mesalamine product.
Indications	All Medically-accepted Indications.
Off Label Uses	

c1 esterase inhibitor

Products Affected

- CINRYZE
- HAEGARDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a allergist, immunologist, or rheumatologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

carbaglu

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

caspofungin

Products Affected

- *caspofungin acetate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

cerdelga

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	Patients with undetermined CYP2D6 metabolizer status.
Required Medical Information	Patient's CYP2D6 metabolizer status, as determined by an FDA approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For reauthorization, documentation has been provided that patient has obtained clinical benefit from medication (e.g. increased platelet count, improvement in anemia, PFTs, improvement in radiographic scans, improved quality of life).
Indications	All Medically-accepted Indications.
Off Label Uses	

cgrp antagonists

Products Affected

- AIMOVIG
- AIMOVIG (140 MG DOSE)
- EMGALITY
- EMGALITY (300 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
Coverage Duration	Initial request will be authorized for 6 months. Reauthorization until end of contract year.
Other Criteria	For a patient newly initiated on CGRP antagonists for migraine prophylaxis: 1) Provider attests that patient has at least 4 migraine days per month or one or more severe migraines lasting for greater than 12 hours despite use of abortive therapy (e.g. triptans or NSAIDs) AND 2) Provider attests that patient has had trial of or medical reason for not using at least two of the following agents: a beta adrenergic blocker, an anti-epileptics (topiramate, valproate or divalproex), venlafaxine, or amitriptyline. For reauthorization a CGRP antagonist for migraine prophylaxis, patient must have experienced reduction of at least 1 headache day per month within the last month of the initial authorization period. For a patient newly initiated on Emgality for treatment of episodic cluster headache: Provider attests that patient has had trial of or medical reason for not using verapamil for at least 4 weeks, at minimum effective doses. For reauthorization for Emgality for the treatment of episodic cluster headache, patient must have documented reduction in the frequency of headaches (clinical benefit).
Indications	All Medically-accepted Indications.
Off Label Uses	

cholbam

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hepatologist or gastroenterologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

cimzia

Products Affected

- CIMZIA PREFILLED
- CIMZIA STARTER KIT
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test) AND 2) Trial of, contraindication to, or medical reason for not using Humira (adalimumab) and Xeljanz or Xeljanz XR (tofacitinib) for appropriate indications.
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

clobazam

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For treatment of Lennox Gastaut Syndrome, patient must have documented trial and failure or intolerance to one formulary anticonvulsant agent that is indicated for Lennox-Gastaut Syndrome. For use in patients with anxiety disorders, the patient must have documented trial and failure or intolerance to one formulary antidepressant (eg SNRI or SSRI).
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

corlanor

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Exclusion Criteria	Blood pressure less than 90/50 mmHg
Required Medical Information	New starts for chronic heart failure must have all of the following: 1) LVEF of 35% or less 2) Have sinus rhythm and have resting heart rate greater than or equal to 70 bpm 3) Blood pressure greater than or equal to 90/50 mmHg and 4) Tried or is currently receiving a beta blocker unless the patient has a contraindication to the use of beta blocker therapy.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a cardiologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

cosentyx

Products Affected

- COSENTYX
- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SENSOREADY PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test) AND 2) Trial of, contraindication to, or medical reason for not using Humira (adalimumab) and Xeljanz or Xeljanz XR (tofacitinib) for appropriate indications.
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

cystagon

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

dalfampiridine er

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	History of seizure or moderate/severe renal impairment (CrCl 50 mL/min or less).
Required Medical Information	For initial requests: 1) Attestation that creatinine clearance (CrCl) greater than 50 mL/min was confirmed prior to initiation of therapy, AND 2) Documentation has been provided that member is ambulatory (able to walk at least 25 feet) and has a documented walking impairment, AND 3) For appropriate indications, member is currently being treated with a disease modifying agent (e.g. immunomodulator, interferon, etc.) or has a medical reason why member is unable to use a disease modifying agent for their condition. For re-authorization requests: 1) Member must experience improvement in walking from baseline due to use of dalfampridine ER.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

deferasirox

Products Affected

- *deferasirox*
- *deferasirox granules*

PA Criteria	Criteria Details
Exclusion Criteria	Patients with GFR less than 40 mL/min/1.73 m(2) or patients with platelet counts less than 50,000/mm3.
Required Medical Information	The following information must be provided for all indications: platelet count within 30 days and GFR greater than 40 mL/min/1.73 m(2). For chronic iron overload due to transfusions laboratory results within 30 days showing serum ferritin concentration greater than 1000 mcg/L). For chronic iron overload in non-transfusion-dependent thalassemia syndromes laboratory results with 30 days showing serum ferritin concentration greater than 300 mcg/L
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

demser

Products Affected

- *metyrosine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of one of the following: 1)Concurrent use of alpha adrenergic blockers 2) medical reason for being unable to use an alpha adrenergic blocker OR 3)patient is not a candidate for surgical resection and requires long term treatment with Demser
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

depen

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the indication of rheumatoid arthritis: Trial of, contraindication to, or medical reason for not using Humira (adalimumab) and Xeljanz or Xeljanz XR (tofacitinib). For other indications, approve.
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

DIACOMIT

Products Affected

- DIACOMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

dificid

Products Affected

- DIFICID ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 10 days.
Other Criteria	Documentation of prior use, or a medical reason for being unable to use oral vancomycin for current infection.
Indications	All Medically-accepted Indications.
Off Label Uses	

doptelet

Products Affected

- DOPTELET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For thrombocytopenia with CLD getting procedure: 5 days. For chronic ITP: remainder of contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

doxepin cream

Products Affected

- *doxepin hcl external*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of trial of, contraindication to, or medical reason for not using a topical corticosteroid.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

dupixent

Products Affected

- DUPIXENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Initial requests for a diagnosis of atopic dermatitis: Documented trial of or medical reason (e.g. very large surface area affected by atopic dermatitis) for not using the following therapies: 1) topical tacrolimus or pimecrolimus AND 2) Eucrisa. Reauthorization requests for a diagnosis of atopic dermatitis: Documentation of clinical benefit from the medication (e.g. BSA improvement from baseline). Initial requests for diagnosis of asthma with eosinophilic phenotype: 1) Documentation has been provided with blood eosinophil count greater than or equal to 150 cells per microliter within 12 months, AND 2) Documentation has been provided indicating patient still is having symptoms with equal to or greater than 2 exacerbations in the previous 12 months requiring additional medical treatment, (e.g. oral systemic steroids) AND 3) If the patient is not able to utilize a high-dose inhaled corticosteroid with a long-acting B2 agonist with or without a leukotriene receptor antagonist OR theophylline, a documented medical reason must be provided why patient is unable to do so. Initial requests for diagnosis of oral corticosteroid asthma, 1) Documentation has been provided indicating patient still is having symptoms with equal to or greater than 2 exacerbations in the previous 12 months requiring additional medical treatment, (e.g. oral systemic steroids) AND 2) If the patient is not able to utilize a high-dose inhaled corticosteroid with a long-acting B2 agonist with or without a leukotriene receptor antagonist OR theophylline, a documented medical reason must be provided why patient is unable to do so. Reauthorization requests for

PA Criteria	Criteria Details
	diagnosis of asthma with eosinophilic phenotype or oral corticosteroid dependent asthma: Documentation of clinical benefit from the medication (e.g. FEV1, reduced exacerbations, eosinophil count). Initial requests for treatment of chronic rhinosinusitis with nasal polyps: Documented trial of or medical reason for not being able to use nasal corticosteroids. Reauthorization for treatment of chronic rhinosinusitis with nasal polyps: Documentation of clinical benefit from the medication (e.g. improvement in symptom severity, reduction in nasal polyp score (NPS)).
Indications	All Medically-accepted Indications.
Off Label Uses	

egrifta

Products Affected

- EGRIFTA SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG
- EGRIFTA SV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of active antiretroviral therapy for at least 8 weeks.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

enbrel

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test) AND 2) Trial of, contraindication to, or medical reason for not using Humira (adalimumab) and Xeljanz or Xeljanz XR (tofacitinib) for appropriate indications.
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

endari

Products Affected

- ENDARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation that patient has had two or more painful sickle cell crises within the past 12 months and that they have been taking hydroxyurea for the past three months or longer.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

epidiolex

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

erythropoetin stimulating agents

Products Affected

- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE
- EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML
- PROCRIT
- RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial therapy, the Hgb must be less than 10 g/dL for all indications or within compendia range for treatment of the requested medical condition. If the request is for Epogen, Procrit, and Retacrit, the provider submitted a documented medical reason (i.e. intolerance, contraindication, hypersensitivity) why they are unable to use Aranesp. For re-authorization, Hgb must not exceed 10 g/dL (cancer), 12 g/dL (zidovudine-treated HIV patients, anemia/chronic kidney disease patients), 13 g/dL (Elective, noncardiac, nonvascular surgery needing red blood cell allogeneic transfusion reduction).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

esbriet

Products Affected

- ESBRIET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diagnosis of idiopathic pulmonary fibrosis: documentation of confirmation of diagnosis on high resolution CT scan or through lung biopsy.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

eucrisa

Products Affected

- EUCRISA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a dermatologist, immunologist or an allergist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documented trial of, contraindication to, or medical reason for not using the following therapies: Topical tacrolimus or pimecrolimus.
Indications	All Medically-accepted Indications.
Off Label Uses	

evrysdi

Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Initial request will be authorized for 6 months. Reauthorization until end of contract year.
Other Criteria	For initial approval, all of the following must be included: 1) Documentation of genetic testing confirming diagnosis AND 2) Documentation of baseline motor function or motor milestone achievement [e.g. CHOP Infant Test of Neuromuscular Disorders (CHOP-INTEND) or Hammersmith Infant Neurological Examination (HINE) for Type 1 or Hammersmith Functional Motor Scale Expanded Scores (HFMSE) for Type II and Type III, or 6 minute walk test in subjects able to walk]. For reauthorization, documentation of clinical response has been submitted (e.g. improvement in motor function/motor milestone achievement scores using CHOP-INTEND or HFMSE, 6 minute walk test or HINE improvement in more categories of motor milestones than worsening, patient remains permanent ventilation free if no prior ventilator support).
Indications	All Medically-accepted Indications.
Off Label Uses	

fentanyl citrate transmucosal products

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation must be provided for the all of the following: 1) fentanyl citrate oral transmucosal is being prescribed to treat cancer-related breakthrough pain AND 2) Patient has been taking opioids at a dose equal to 60 MME per day for at least one week.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ferriprox

Products Affected

- *deferiprone*
- FERRIPROX ORAL TABLET 1000 MG
- FERRIPROX TWICE-A-DAY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial therapy, documentation of the patient's serum ferritin level above 2,500 mcg/L and absolute neutrophil count (ANC) greater than 1.5x10^9/L within 30 days of request.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For continuation of therapy, documentation of a decrease in serum ferritin from baseline.
Indications	All Medically-accepted Indications.
Off Label Uses	

fintepla

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	The request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

firdapse

Products Affected

- FIRDAPSE

PA Criteria	Criteria Details
Exclusion Criteria	History of seizures.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

forteo

Products Affected

- FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation showing patient falls into one of the following categories:Postmenopausal woman who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or postmenopausal woman who has had an osteoporotic fracture.Postmenopausal woman who has T-scores from -1.5 to -2.5 and at least one of the following risk factors for fracture: thinness [low body mass index (less than 21 kg/m2)], history of fragility fracture since menopause, or history of hip fracture in a parent. Male greater than or equal to 65 years of age with T-score of -2.5 or less. Male less than 65 years of age with T-score of -2.5 or less and 2 or more risk factors for fractures or previous osteoporotic fracture.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	In addition, the following criteria is also applicable: The patient has a documented treatment failure or has a documented medical reason (intolerance, hypersensitivity, contraindication, etc) for not utilizing an oral bisphosphonate to manage their medical condition AND The therapy does not exceed the therapy maximum of 2 years.
Indications	All Medically-accepted Indications.
Off Label Uses	

galafold

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

gattex

Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Provider is a gastroenterologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

gnrh agonists

Products Affected

- ELIGARD
- FIRMAGON
- FIRMAGON (240 MG DOSE)
- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)
- LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 7.5 MG
- LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (PED)
- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If the medication request is for the treatment of prostate cancer and if the request is for any other GnRH agonist other than Eligard, the patient must have a documented trial of, contraindication to, or medical reason for not using Eligard to treat their prostate cancer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

gocovri

Products Affected

- GOCOVRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	New starts: trial of, contraindication to, or medical reason for not using generic amantadine. Continuation of therapy: improvement in levodopa-induced dyskinesia due to use of Gocovri.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Initial request will be authorized for 3 months. Reauthorization until end of contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

growth hormones

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- HUMATROPE
- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- OMNITROPE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial request for growth hormone deficiency: documentation showing Growth Hormone Stimulation Test results, Insulin Growth Factor 1 level, bone age testing, height, and weight. Initial requests for all other medically accepted indications other than growth hormone deficiency, the request will be approved. For reauthorization for growth hormone deficiency: documentation (medical records) showing positive response to treatment.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an endocrinologist or nephrologist
Coverage Duration	Initial request will be authorized for 6 months. Reauthorization until end of contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

h. p. acthar

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial request for MS exacerbation, rheumatic disorders, collagen diseases, dermatologic diseases, serum sickness, ophthalmic disease and respiratory diseases, documentation is submitted indicating trial of, contraindication to, or medical reason for not using high-dose parenteral corticosteroids to manage their medical condition. Reauthorization criteria for continuation of therapy for MS exacerbation: documentation of symptom improvement and confirmation that member is currently on maintenance therapy with a multiple sclerosis disease modifying agent. Reauthorization criteria for all other conditions: documented evidence of disease response to treatment as indicated by improvement in symptoms.
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	MS exacerbation: 1 month. Other conditions: initial for 3 months and reauth end of contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

hetlioz

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Provider is a sleep specialist or neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

high dose opioid

Products Affected

- *fentanyl transdermal patch 72 hour 100 mcg/hr*
- *methadone hcl oral tablet 10 mg*
- *morphine sulfate er oral tablet extended release 100 mg, 200 mg*
- *oxycodone hcl er oral tablet er 12 hour abuse-deterrent*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Members being treated for active cancer diagnoses, sickle cell diagnoses, those in hospice care, or receiving palliative care will be approved. For new starts, ALL of the following are required: (1) Taking opioids at a dose equal to 60 MME per day for at least one week, (2) Current regimen is the lowest possible effective dose of opioid therapy, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary (4) Member is not being treated for substance abuse with buprenorphine-containing products. For continuing therapy, ALL of the following are required: (1) Member's pain has been assessed within the last 6 months, (2) Member has demonstrated clinical improvement in pain and function on current medication regimen, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary, (4) Member is not being treated for substance abuse with buprenorphine-containing products.
Indications	All Medically-accepted Indications.
Off Label Uses	

high risk medication

Products Affected

- *clemastine fumarate oral tablet 2.68 mg*
- *cyproheptadine hcl oral*
- *dipyridamole oral*
- *disopyramide phosphate oral*
- *ergoloid mesylates oral*
- *glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg*
- *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*
- *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg*
- *guanfacine hcl er*
- *guanfacine hcl oral*
- *hydroxyzine hcl oral syrup*
- *hydroxyzine hcl oral tablet 25 mg, 50 mg*
- *hydroxyzine pamoate oral*
- *indomethacin er*
- *indomethacin oral capsule 25 mg, 50 mg*
- *ketorolac tromethamine oral*
- *megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 625 mg/5ml*
- *meperidine hcl oral solution*
- *meperidine hcl oral tablet*
- *methyldopa oral*
- *methyldopa-hydrochlorothiazide*
- *nifedipine oral*
- NORPACE CR
- *pentazocine-naloxone hcl*
- *promethazine hcl oral*
- *promethazine hcl rectal suppository 12.5 mg, 25 mg*
- *promethazine vc*
- *promethazine vc plain oral solution*
- *promethazine-phenylephrine*
- PROMETHEGAN RECTAL SUPPOSITORY 50 MG
- *trihexyphenidyl hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For patients 65 years old and older: The prescriber has documented the indication for the use of the high risk medication with an explanation of the specific benefit with the medication, and how that benefit outweighs the potential risk. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.

PA Criteria	Criteria Details
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

high risk medication - protected class drugs

Products Affected

- *amitriptyline hcl oral*
- *amoxapine*
- *clomipramine hcl oral*
- *doxepin hcl oral capsule*
- *doxepin hcl oral concentrate*
- *imipramine hcl oral*
- *imipramine pamoate*
- *megestrol acetate oral tablet*
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- *perphenazine-amitriptyline*
- *phenobarbital oral*
- *protriptyline hcl*
- *trimipramine maleate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For patients 65 years old and older: The prescriber has documented the indication for the use of the high risk medication with an explanation of the specific benefit with the medication, and how that benefit outweighs the potential risk. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

high risk medication, butalbital

Products Affected

- ASCOMP-CODEINE
- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*
- *butalbital-apap-caffeine oral capsule 50-325-40 mg*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*
- *butalbital-asa-caff-codeine*
- *butalbital-asa-caffeine*
- *butalbital-aspirin-caffeine oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For patients 65 years old and older: The prescriber has documented the indication for the use of the high risk medication with an explanation of the specific benefit with the medication, and how that benefit outweighs the potential risk. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication. Additionally, documentation was submitted of adequate trials and/or medical reason (e.g. intolerance or hypersensitivity) for not utilizing this therapy to manage their medical condition: one formulary oral NSAID
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

high risk medication, digoxin

Products Affected

- DIGITEK ORAL TABLET 250 MCG
- DIGOX ORAL TABLET 250 MCG
- *digoxin oral solution*
- *digoxin oral tablet 250 mcg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For patients 65 years old and older: Patient must have documented trial and failure to doses up to 0.125mg per day OR the prescriber has documented the indication for the use of doses greater than 0.125mg per day. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

high risk medication, short term muscle relaxant

Products Affected

- *carisoprodol oral*
- *carisoprodol-aspirin-codeine*
- *chlorzoxazone oral tablet 500 mg*
- CYCLOBENZAPRINE COMFORT PAC
- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*
- CYCLOTENS REFILL PAK
- CYCLOTENS STARTER PAK
- *metaxalone oral tablet 800 mg*
- *methocarbamol oral*
- *orphenadrine citrate er*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For patients 65 years old and older: The prescriber has documented the indication for the use of the high risk medication with an explanation of the specific benefit with the medication, and how that benefit outweighs the potential risk. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	
Coverage Duration	Initial request will be authorized for 30 days. Reauthorizaton will be for 90 days.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

high risk medication, sleep agents

Products Affected

- *eszopiclone*
- *temazepam*
- *zaleplon*
- *zolpidem tartrate er*
- *zolpidem tartrate oral tablet 10 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For patients 65 years old and older: The prescriber has documented the indication for the use of the high risk medication with an explanation of the specific benefit with the medication, and how that benefit outweighs the potential risk. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication. For requests for zolpidem immediate release 10 mg and zolpidem ER, documentation has been submitted of adequate trials and/or medical reason (e.g. intolerance or hypersensitivity) for not utilizing this therapy to manage their medical condition: zolpidem immediate release 5 mg.
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

humira

Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA PEN-CD/UC/HS STARTER
- HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML
- HUMIRA PEN-PSOR/UVEIT STARTER
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For all indications, documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test). For Hidradenitis suppurativa: confirmation of Hurley Stage II or III disease. Trial of, contraindication to, or medical reason for not using the following if applicable for submitted diagnosis: 1) For Rheumatoid Arthritis, Psoriatic Arthritis, or Juvenile Idiopathic Arthritis: one DMARD (e.g. methotrexate, sulfasalazine, generic leflunomide (Arava), etc.), 2) For Ankylosing Spondylitis: two nonsteroidal anti-inflammatory drugs (NSAIDS), 3) For Plaque Psoriasis: one of the following: moderate to high potency topical steroids, topical calcipotriene, Tazorac (tazarotene), Methotrexate, UVB phototherapy and/or PUVA therapy. 4) For Crohn's Disease and Ulcerative Colitis: one conventional oral therapy (e.g. azathioprine, sulfasalazine, prednisone, mesalamine products). 5) For Non-infectious Uveitis: one ophthalmic corticosteroid.
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ICATIBANT

Products Affected

- *icatibant acetate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

increlex

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

intravitreal injections

Products Affected

- BEOVU
- EYLEA INTRAVITREAL
- LUCENTIS INTRAVITREAL
- MACUGEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an optometrist or ophthalmologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Patient must have a documented trial of, contraindication to, or medical reason for not using intravitreal bevacizumab.
Indications	All Medically-accepted Indications.
Off Label Uses	

intron-a

Products Affected

- INTRON A

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

juxtapid

Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Patients with moderate or severe hepatic impairment (Child- Pugh B or C) or active liver disease.
Required Medical Information	Documentation of treatment history, trial and failure after three months with Repatha or has a documented medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing Repatha to manage their condition. In addition, a fasting lipid panel report with abnormal LDL cholesterol results (over 70mg/dL) and baseline LFTs and bilirubin, along with patient's Child Pugh Score are required within 90 days of request.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a cardiologist, specialist in treatment of lipid disorders or endocrinologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

jynarque

Products Affected

- JYNARQUE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that transaminases and bilirubin will be monitored prior to initiation and throughout duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a nephrologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

kalydeco

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Orkambi, Symdeko, or Trikafta.
Required Medical Information	Documentation of cystic fibrosis mutation responsive to ivacaftor treatment.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

keveyis

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial request: documentation of trial of, contraindication to, or medical reason for not using acetazolamide. For reauthorization: documentation of clinical improvement with therapy.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a geneticist, neurologist, or endocrinologist.
Coverage Duration	Initial request will be authorized for 2 months. Reauthorization until end of contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

kineret

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test) AND 2) Trial of, contraindication to, or medical reason for not using Humira (adalimumab) and Xeljanz or Xeljanz XR (tofacitinib) for appropriate indications.
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

korlym

Products Affected

- KORLYM

PA Criteria	Criteria Details
Exclusion Criteria	For all members patient must not be currently on simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quididine, sirolimus, and tacrolimus.
Required Medical Information	Reviewer will verify available claim history to confirm member is not taking simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quididine, sirolimus or tacrolimus concurrently with Korylm.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

kuvan

Products Affected

- *sapropterin dihydrochloride*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial therapy, documentation of elevated baseline phenylalanine levels. For reauthorization, prescriber attests the member has improvement in phenylalanine levels from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial request will be authorized for 3 months. Reauthorization until end of contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

kynmobi

Products Affected

- KYNMOBI

PA Criteria	Criteria Details
Exclusion Criteria	Kynmobi (apomorphine hydrochloride) is contraindicated in concomitant use with serotonin 5-HT3 receptor antagonists.
Required Medical Information	Reviewer will verify available patient claim history to confirm patient is not using 5-HT3 receptor antagonists. If diagnosis is Parkinsons, the patient has a documented trial and failure or intolerance to two formulary alternatives such as entacapone, tolcapone, rasagiline, selegiline, carbidopa/levodopa, bromocriptine, pramipexole or ropinirole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

lucemyra

Products Affected

- LUCEMYRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial therapy, patient must have documented trial of, contraindication to, or medical reason for not using clonidine. Reauthorization criteria: chart notes that show positive response to prior treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 14 days.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

mavyret

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Labs within 3 months of request: ALT/AST, detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, or transplant specialist.
Coverage Duration	Request will be authorized for 8-16 weeks as per AASLD-IDSA guidance.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

methyltestosterone

Products Affected

- *methyltestosterone oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

multiple sclerosis agents

Products Affected

- AUBAGIO
- BAFIERTAM
- BETASERON SUBCUTANEOUS KIT
- *dimethyl fumarate oral*
- *dimethyl fumarate starter pack*
- EXTAVIA SUBCUTANEOUS KIT
- GILENYA ORAL CAPSULE 0.5 MG
- *glatiramer acetate*
- GLATOPA
- KESIMPTA
- MAYZENT
- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- TECFIDERA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If the medication request is for glatiramer, Glatopa, Aubagio, or Mayzent, the request will be approved. If the request is not for glatiramer, Glatopa, Aubagio, or Mayzent, the member must have a documented trial of, contraindication to or a medical reason for not using two of the following agents: Aubagio, glatiramer/Glatopa, or Mayzent.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

natpara

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of serum calcium greater than 7.5 mg/dL and vitamin D level (within 30 days of request).
Age Restrictions	
Prescriber Restrictions	Provider is an endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

nexletol

Products Affected

- NEXLETOL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	Initial request will be authorized for 4 months. Reauthorization until end of contract year.
Other Criteria	For initial requests ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C) 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin 3) Member has tried and failed ezetimibe at a maximum tolerated dose or documentation has been provided that the patient is not able to tolerate ezetimibeAND 4) Member will continue on maximum tolerated statin dose and ezetimibe dose while receiving Nexletol or documentation has been provided that the member is not able to tolerate a statin and/or ezetimibe.In addition to the initial criteria above if the initial request is for the diagnosis of hyperlipidemia and atherosclerotic cardiovascular disease (ASCVD), the following are required: 1) Documentation of history of least one of the following: myocardial infarction or acute coronary syndrome, stroke or transient ischemic attack, coronary artery disease with stable angina, coronary or other arterial revascularization, peripheral vascular disease, or aortic aneurysm AND 2) Member must have a fasting LDL-C greater than or equal to 70 mg/dL. For reauthorization requests for all indications: 1) Documentation provided that the member has obtained clinical benefit from medication (e.g. LDL-C lowering from baseline) AND 2) Member will continue on maximum tolerated statin and ezetimibe dose while

PA Criteria	Criteria Details
	receiving Nexletol or documentation has been provided that the member is not able to tolerate a statin and/or ezetimibe.
Indications	All Medically-accepted Indications.
Off Label Uses	

nexlizet

Products Affected

- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	Initial request will be authorized for 4 months. Reauthorization until end of contract year.
Other Criteria	For initial requests ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C), 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin, AND 3) Member will continue on maximum tolerated statin dose while receiving Nexlizet or documentation has been provided that the member is not able to tolerate a statin. In addition to the initial criteria above if the initial request is for the diagnosis of hyperlipidemia and atherosclerotic cardiovascular disease (ASCVD), the following are required: 1) Documentation of history of least one of the following: myocardial infarction or acute coronary syndrome, stroke or transient ischemic attack, coronary artery disease with stable angina, coronary or other arterial revascularization, peripheral vascular disease, or aortic aneurysm, AND 2) Member must have a fasting LDL-C greater than or equal to 70 mg/dL. For reauthorization requests for all indications: 1) Documentation provided that the member has obtained clinical benefit from medication (e.g. LDL-C lowering from baseline), AND 2) Member will continue on maximum tolerated statin while receiving Nexlizet or documentation has been provided that the member is not able to tolerate a statin.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	

nitisinone

Products Affected

- *nitisinone*
- ORFADIN ORAL CAPSULE 20 MG
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

nityr

Products Affected

- NITYR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

noctiva

Products Affected

- NOCTIVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Provider attests that eGFR and serum sodium will be monitored throughout the duration of the therapy, and that the patient does not have baseline hyponatremia or primary nocturnal enuresis. AND 2) For patients newly starting on Noctiva: For respective indications, patient must have shown either a lack of benefit during trial of one of the following medications, or is experiencing nocturia unrelated to any of the following etiologies. Nocturia secondary to lower urinary tract symptoms or benign prostate enlargement: trial of alpha adrenergic antagonists (e.g. tamsulosin, alfuzosin). Nocturia secondary to benign prostate hyperplasia: trial of alpha adrenergic antagonist and 5-alpha reductase inhibitor (e.g. finasteride). Nocturia due to nocturnal polyuria: trial of bumetanide during daytime. Nocturia secondary to overactive bladder: trial of an antimuscarinic agent (e.g. oxybutynin).
Age Restrictions	
Prescriber Restrictions	Prescriber must be a urologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

non-amphetamine central nervous system agents

Products Affected

- *armodafinil*
- *modafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

noxafil

Products Affected

- NOXAFIL ORAL SUSPENSION
- *posaconazole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	28 days for oropharyngeal candidiasis, end of contract year for other indications
Other Criteria	For treatment of oropharyngeal candidiasis, there must be documentation of either at least a one week trial or a medical reason (e.g. intolerance, known resistance, hypersensitivity) for not being able to use one of the following agents: fluconazole or itraconazole
Indications	All Medically-accepted Indications.
Off Label Uses	

nucala

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial Authorization for severe asthma: 1) Documentation has been provided with blood eosinophil count greater than or equal to 150 cells per microliter within 6 weeks or 300 cells per microliter within 12 months AND 2) Documentation has been provided indicating patient still is having symptoms with equal to or greater than 2 exacerbations in the previous 12 months requiring additional medical treatment, (e.g. oral systemic steroids) AND 3) If the patient is not able to utilize a high-dose inhaled corticosteroid with a long-acting B2 agonist with or without a leukotriene receptor antagonist OR theophylline, a documented medical reason must be provided why patient is unable to do so. Initial authorization for eosinophilic granulomatosis with polyangiitis (EGPA): Trial of, contraindication to, or medical reason for not using one of the following medications: cyclophosphamide or methotrexate. Re-Authorization for all indications: Documentation submitted indicates the member has clinically benefited from the medication (FEV1, reduced exacerbations, eosinophil count, etc.).
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Initial request will be approved for 6 months. All subsequent requests will be approved for 1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

nuedexta

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

nuplazid

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG, 17 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ocaliva

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	Members with complete biliary obstruction.
Required Medical Information	For new starts: 1) Attestation that the member has failed at least a 12 month trial of ursodiol, or has a medical reason (e.g. intolerance, hypersensitivity) for being unable to tolerate ursodiol AND 2) lab results for baseline ALT/AST, alkaline phosphatase (ALP), and bilirubin within 90 days of request. Reauthorization: Documentation that that the member has responded to Ocaliva (e.g. improved biochemical markers (e.g., ALP, bilirubin, GGT, AST, ALT levels)).
Age Restrictions	
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or transplant specialist.
Coverage Duration	Initial request will be authorized for 4 months. Reauthorization until end of contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

octreotide acetate

Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*
- SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If the request is for generic octreotide and the criteria are met, the request will be approved. If the request is for an agent other than generic octreotide, documentation must be provided showing an adverse event or inadequate response associated with use of the generic agent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ofev

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For a diagnosis of idiopathic pulmonary fibrosis: 1) Documentation of disease as demonstrated on a high resolution CT scan or through lung biopsy and 2) Documented trial of, contraindication to, or medical reason for not using Esbriet. For a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD): documented trial of, contraindication to, or medical reason for not using mycophenolate mofetil or cyclophosphamide.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

oral antineoplastic agents

Products Affected

- *abiraterone acetate oral tablet 250 mg*
- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG
- ALECENSA
- ALUNBRIG
- BALVERSA
- BOSULIF
- BRAFTOVI ORAL CAPSULE 75 MG
- CABOMETYX
- CALQUENCE
- CAPRELSA
- COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)
- COPIKTRA
- COTELLIC
- DAURISMO
- ERIVEDGE
- ERLEADA
- *erlotinib hcl*
- *everolimus oral tablet 2.5 mg, 5 mg, 7.5 mg*
- FARYDAK
- GAVRETO
- GILOTRIF
- GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG
- IBRANCE
- ICLUSIG
- IDHIFA
- *imatinib mesylate*
- IMBRUVICA
- INLYTA
- INQOVI
- INREBIC
- IRESSA
- JAKAFI
- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)
- KISQALI FEMARA (400 MG DOSE)
- KISQALI FEMARA (600 MG DOSE)
- KISQALI FEMARA(200 MG DOSE)
- KOSELUGO
- *lapatinib ditosylate*
- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)
- LONSURF
- LORBRENA
- LYNPARZA
- MEKINIST
- MEKTOVI
- NERLYNX
- NEXAVAR
- NINLARO
- NUBEQA
- ODOMZO
- ONUREG
- PEMAZYRE
- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)
- POMALYST
- QINLOCK
- RETEVMO
- REVLIMID
- ROZLYTREK
- RUBRACA
- RYDAPT
- SPRYCEL
- STIVARGA
- SUTENT
- TABLOID
- TABRECTA
- TAFINLAR
- TAGRISSO

Formulary ID 21351
Last Updated: 01/2021

- TALZENNA
- TASIGNA
- TIBSOVO
- *toremifene citrate*
- TUKYSA
- TURALIO
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VERZENIO
- VITRAKVI
- VIZIMPRO
- VOTRIENT
- XALKORI
- XOSPATA
- XPOVIO (100 MG ONCE WEEKLY)
- XPOVIO (40 MG ONCE WEEKLY)
- XPOVIO (40 MG TWICE WEEKLY)
- XPOVIO (60 MG ONCE WEEKLY)
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY)
- XPOVIO (80 MG TWICE WEEKLY)
- XTANDI
- YONSA
- ZEJULA
- ZELBORAF
- ZOLINZA
- ZYDELIG
- ZYKADIA ORAL TABLET
- ZYTIGA ORAL TABLET 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

oral antipsychotics

Products Affected

- CAPLYTA
- FANAPT
- FANAPT TITRATION PACK
- LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG
- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For a diagnosis of schizophrenia and manic or mixed episodes associated with bipolar l disorder, the patient must have documented trial and failure or intolerance to one formulary generic antipsychotics (aripiprazole, risperidone, olanzapine, quetiapine, or ziprasidone) AND Saphris. For major depressive disorder associated with bipolar l disorder, the patient must have documented trial and failure or intolerance to two formulary generic antipsychotics (aripiprazole, risperidone, olanzapine, quetiapine, or ziprasidone).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

orencia

Products Affected

- ORENCIA CLICKJECT
- ORENCIA INTRAVENOUS
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test) AND 2) Trial of, contraindication to, or medical reason for not using Humira (adalimumab) and Xeljanz or Xeljanz XR (tofacitinib) for appropriate indications.
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

orilissa

Products Affected

- ORILISSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of trial of or medical reason for not being able to use at least two of following classes used concurrently for the treatment of endometriosis: analgesic pain reliever (e.g. NSAIDs, COX-2 inhibitors) AND either combined estrogen-progestin oral contraceptive, progestin (e.g. medroxyprogesterone acetate, norethindrone), gonadotropin-releasing hormone (GnRH) agonists (e.g. Lupron Depot), OR danazol. For reauthorization, patient must have continued benefit with use of agent.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an OB/GYN.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

orkambi

Products Affected

- ORKAMBI ORAL PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Symdeko, or Trikafta.
Required Medical Information	Documentation of genetic test confirming patient is homozygous for the F508del mutation or a mutation that is responsive to lumacaftor-ivacaftor treatment.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

otezla

Products Affected

- OTEZLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If the request is for treatment of Behcet's disease, the request will be approved. If the request is for plaque psoriasis, patient must have trial of, contraindication to, or medical reason for not using Humira (adalimumab). If the request is for psoriatic arthritis, patient must have trial of, contraindication to, or medical reason for not using Humira (adalimumab) and Xeljanz or Xeljanz XR (tofacitinib).
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

oxbryta

Products Affected

- OXBRYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Presciber must be a hematologist
Coverage Duration	Initial request will be approved for 6 months. Reauthorization will be approved for 12 months
Other Criteria	Initial Authorization: Baseline labs have been submitted for the following: Hemoglobin (Hb), Indirect bilirubin, Reticulocytes. Documentation was provided that the member has had 1 or more pain crises in the last 12 months. Member has a baseline Hb level less than 10.5 g/dL. Documentation was provided that the member has been taking hydroxyurea at the maximum tolerated dose (or a medical reason was provided why the patient is unable to use hydroxyurea) Reauthorization: Documentation submitted indicates clinical benefit at 6 months from initiation, and continued clinical benefit at subsequent 12-month intervals defined as the following: Documentation of one of the following: Hb increase from baseline (at 6 months from initiation) or maintenance of such Hb increase (at 12-month intervals thereafter) Or documentation of reduced number of vaso-occlusive/pain crises since Oxbryta was started Or documentation of one of the following: Decrease in indirect bilirubin from baseline Or decrease in percentage of reticulocytes from baseline
Indications	All Medically-accepted Indications.
Off Label Uses	

oxervate

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an ophthalmologist.
Coverage Duration	The request will be authorized for 8 weeks.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

oxsoralen ultra

Products Affected

- *methoxsalen rapid*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Patient must have documented trial and failure or intolerance to methotrexate.
Indications	All Medically-accepted Indications.
Off Label Uses	

oxycodone er

Products Affected

- *oxycodone hcl er oral tablet er 12 hour abuse-deterrent*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Members being treated for active cancer diagnoses, sickle cell diagnoses, those in hospice care, or receiving palliative care will be excluded from the concurrent benzodiazepine and muscle relaxant therapy requirement. For new starts, ALL of the following are required: (1) Member has documented history of receiving an immediate-release opioid, (2) Member has a documented trial of or intolerance to long-acting morphine sulfate, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary, (4) Member is not being treated for substance abuse with buprenorphine-containing products. For continuing therapy, ALL of the following are required: (1) Member's pain has been assessed within the last 6 months, (2) Member has demonstrated clinical improvement in pain and function on current medication regimen, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary, (4) Member is not being treated for substance abuse with buprenorphine-containing products.
Indications	All Medically-accepted Indications.
Off Label Uses	

paliperidone

Products Affected

- *paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For the diagnosis of schizophrenia: the patient must have documented failure or intolerance to a formulary second generation atypical antipsychotic
Indications	All Medically-accepted Indications.
Off Label Uses	

paliperidone long acting

Products Affected

- INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 39 MG/0.25ML, 78 MG/0.5ML
- INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.875ML, 410 MG/1.315ML, 546 MG/1.75ML, 819 MG/2.625ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The member has a documented history of receiving oral risperidone or oral paliperidone without any clinically significant side effects. For requests for Invega Trinza, the member has documented treatment with Invega Sustenna for at least 4 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

pcsk9 inhibitors

Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	Initial: authorized for 4 months. Reauthorization: authorized until the end of the contract year.
Other Criteria	For ALL diagnoses (including primary hyperlipedemia) for initial approval: documentation (copy of dated lab results required) of two fasting lipid panel reports within the past 12 months with abnormal LDL cholesterol results (above 70mg/dL) after treatment for a minimum of 3 months with two high potency statins (atorvastatin and rosuvastatin) or a medical reason (contraindication or intolerance) has been provided as to why the patient is unable to use these therapies. If patient experiences intolerance, documentation that patient has undergone a trial of statin re-challenge with maximally tolerated dose of statins with continued abnormal LDL cholesterol results (above 70mg/dL) or with documented return of side effects. If diagnosis is familial hypercholesterolemia (FH), additional documentation has been provided including TWO of the following: 1) genetic testing (copy of dated lab results required) confirming FH diagnosis OR 2) clinical manifestations of FH such as xanthomas or inflamed tendons OR 3) a clinical diagnosis of FH using the Dutch Lipid Clinic Diagnostic criteria (total score greater than 8 points), OR Simon-Broome Diagnostic criteria (total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree parent, sibling or child) or second-degree relative (grandparent, uncle or aunt). If diagnosis is ASCVD, additional documentation has been provided that includes history of acute coronary syndromes, history of MI, stable or unstable angina, coronary or other

PA Criteria	Criteria Details
	arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin. For ALL diagnoses for initial reauthorization: patient has had repeat LDL cholesterol lab (copy of dated lab result required) showing improvement in LDL from initial request. For all other reauthorization requests, LDL cholesterol lab (copy of dated lab result required) was submitted with request.
Indications	All Medically-accepted Indications.
Off Label Uses	

peginterferon

Products Affected

- PEGASYS SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Hepatitis C: Labs within 3 months of request: ALT/AST, and detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis. For Hepatitis B: Labs within 3 months of request: ALT/AST. In addition, documentation of HBeAg status is required.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, infectious disease doctor or transplant specialist.
Coverage Duration	Request will be authorized for up to 48 weeks as defined by compendia.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

pentamidine solution for injection

Products Affected

- *pentamidine isethionate injection*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

perseris

Products Affected

- PERSERIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

phenoxybenzamine

Products Affected

- *phenoxybenzamine hcl oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

pretomanid

Products Affected

- *pretomanid*

PA Criteria	Criteria Details
Exclusion Criteria	MDR-TB that is not treatment-intolerant or nonresponsive to standard therapy
Required Medical Information	Documentation of use in combination with bedaquiline and linezolid. Laboratory confirmed pulmonary MDR-TB resistant to isoniazid and rifampin
Age Restrictions	
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist
Coverage Duration	Request will be authorized for 26 weeks.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

prevymis

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, infectious disease, or transplant specialist.
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

prolia

Products Affected

- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For a diagnosis of osteoporosis: Documentation showing patient falls into one of the following categories: Postmenopausal woman or a male patient who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than - 2.5) or who has had an osteoporotic fracture. Postmenopausal woman or man with a T-score between -1 and -2.5 at the femoral neck or spine and a 10 year hip fracture probability greater than 3% or a 10 year major osteoporosis-related fracture probability greater than 20% based on the US-adapted WHO absolute fracture risk model.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	The following criteria is also applicable: trial of, contraindication to, or medical reason for not using an oral bisphosphonate.
Indications	All Medically-accepted Indications.
Off Label Uses	

promacta

Products Affected

- PROMACTA ORAL PACKET
- PROMACTA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ravicti

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Provider is a geneticist, metabolic specialist, gastroenterologist, hepatologist, or liver transplant specialist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

regranex

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 20 weeks.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

relistor

Products Affected

- RELISTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For appropriate indications, patient must have documented trial of or medical reason for not using the following: 1) Amitiza, AND 2) lactulose. Additionally, for constipation caused by opioids that are used for chronic, non-cancer pain, patient must have a medical reason for not being able to use oral Relistor in order to receive Relistor injection.
Indications	All Medically-accepted Indications.
Off Label Uses	

renflexis

Products Affected

- RENFLEXIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test) AND 2) Trial of, contraindication to, or medical reason for not using Humira (adalimumab) and Xeljanz or Xeljanz XR (tofacitinib) for appropriate indications
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

rexulti

Products Affected

- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For a diagnosis of schizophrenia the patient must have documented trial and failure or intolerance to one formulary generic antipsychotic (aripiprazole, risperidone, olanzapine, quetiapine, or ziprasidone) AND Saphris. For major depressive disorder, the patient must have documented trial and failure or intolerance to two of the following: escitalopram, sertraline, fluoxetine, paroxetine, venlafaxine, venlafaxine ER, citalopram, mirtazapine, desvenlafaxine or duloxetine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

risperdal consta

Products Affected

- RISPERDAL CONSTA
  INTRAMUSCULAR SUSPENSION
  RECONSTITUTED ER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

secuado

Products Affected

- SECUADO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient must have documented trial and failure or intolerance to one formulary generic antipsychotics (aripiprazole, risperidone, olanzapine, quetiapine, or ziprasidone) AND Saphris
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

serostim

Products Affected

- SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a HIV specialist.
Coverage Duration	Request will be authorized for 12 weeks.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

signifor

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

sildenafil oral

Products Affected

- *sildenafil citrate oral suspension reconstituted*
- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of concurrent nitrate or Adempas use.
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using nitrates or Adempas.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	For sildenafil suspension: Documentation of trial of, contraindication to, or medical reason for not using sildenafil tablet.
Indications	All Medically-accepted Indications.
Off Label Uses	

SIMPONI

Products Affected

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test) AND 2) Trial of, contraindication to, or medical reason for not using Humira (adalimumab) and Xeljanz or Xeljanz XR (tofacitinib) for appropriate indications.
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

sirturo

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prior trial of or medical reason for not using first-line TB regimen containing isoniazid and rifampin. Documentation (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) that the member is currently taking 3 additional antimycobacterial drugs in combination to treat MDR-TB.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 24 weeks.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

sodium phenylbutyrate

Products Affected

- *sodium phenylbutyrate oral powder 3 gm/tsp*
- *sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

sofosbuvir/velpatasvir

Products Affected

- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Labs within 3 months of request: ALT/AST, and detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, or transplant specialist.
Coverage Duration	Request will be authorized for 12-24 weeks based on AASLD-IDSA guidelines
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

soliris

Products Affected

- SOLIRIS INTRAVENOUS SOLUTION
  300 MG/30ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For patients with a diagnosis of generalized myasthenia gravis, the patient tried and failed ALL of the following therapies: one formulary acetylcholinesterase inhibitor (i.e. pyridostigmine), one formulary immunomodulating agent (i.e. cyclosporine, mycophenolate, azathioprine, glucocorticoids), Intravenous immunoglobulin (IVIG), and rituximab.
Age Restrictions	
Prescriber Restrictions	Neurologist, hematologist/oncologist, immunologist, nephrologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

somavert

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

stelara

Products Affected

- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test) AND 2) Trial of, contraindication to, or medical reason for not using Humira (adalimumab) and Xeljanz or Xeljanz XR (tofacitinib) for appropriate indications.
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

sucraid

Products Affected

- SUCRAID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

sylatron

Products Affected

- SYLATRON SUBCUTANEOUS KIT
  200 MCG, 300 MCG, 600 MCG

PA Criteria	Criteria Details
Exclusion Criteria	A history of autoimmune hepatitis or hepatic decompensation (Child-Pugh greater than 6[class B and C]).
Required Medical Information	For appropriate indication, documentation of definitive surgical resection including complete lymphadenectomy within 84 days of initiating treatment.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

symdeko

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Orkambi, or Trikafta.
Required Medical Information	Documentation of genetic test confirming patient is homozygous for the F508del mutation or a mutation that is responsive to tezacaftor-ivacaftor treatment.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

symlin

Products Affected

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For new starts HbA1C values within 90 days of request should be provided showing the following: 1) for patients with type 2 diabetes HbA1C is greater than or equal to 8% despite receiving insulin therapy or 2) for pateints with type 1 diabetes, HbA1C is greater than or equal to 7% despite receiving insulin therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Patient must have documented trial or intolerance to two formulary anti-diabetic agents.
Indications	All Medically-accepted Indications.
Off Label Uses	

synarel

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

syndros

Products Affected

- SYNDROS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documentation of either trial/failure or a medical reason (e.g. intolerance or hypersensitivity) for not being able to use dronabinol capsules
Indications	All Medically-accepted Indications.
Off Label Uses	

synribo

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tazverik

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

teflaro

Products Affected

- TEFLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 14 days.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

thalomid

Products Affected

- THALOMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

thiola

Products Affected

- THIOLA
- THIOLA EC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

topical antineoplastic retinoids

Products Affected

- PANRETIN
- TARGRETIN EXTERNAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

topical testosterone

Products Affected

- *testosterone transdermal gel 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient initiating topical testosterone therapy for hypogonadism must have both of the following characteristics of hypogonadism: 1) symptoms associated with hypogonadism (e.g. unexplained mild anemia, low libido, decreased energy, etc.) 2) Two instances of low serum total or free testosterone, as defined by the reference range by the lab. For all patients, provider attests that PSA levels, hemoglobin, hematocrit and testosterone levels will be monitored periodically throughout the treatment as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

transdermal lidocaine

Products Affected

- *lidocaine external patch 5 %*
- LIDOPURE PATCH
- ZILACAINE PATCH
- ZTLIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tremfya

Products Affected

- TREMFYA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test) AND 2) Trial of, contraindication to, or medical reason for not using Humira (adalimumab) and Xeljanz or Xeljanz XR (tofacitinib) for appropriate indications.
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

trientine

Products Affected

- *trientine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented penicillamine intolerance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

trikafta

Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis mutation
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in treatment of cystic fibrosis
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tymlos

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation showing patient falls into one of the following categories: Postmenopausal woman who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or postmenopausal woman who has had an osteoporotic fracture. Postmenopausal woman who has T-scores from -1.5 to -2.5 and at least one of the following risk factors for fracture: thinness [low body mass index (less than 21 kg/m2)], history of fragility fracture since menopause, or history of hip fracture in a parent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	The following criteria is also applicable: 1) trial of, contraindication to, or medical reason for not using an oral bisphosphonate and Prolia, and 2) therapy does not exceed 2 years.
Indications	All Medically-accepted Indications.
Off Label Uses	

valtoco

Products Affected

- VALTOCO 10 MG DOSE
- VALTOCO 15 MG DOSE
- VALTOCO 20 MG DOSE
- VALTOCO 5 MG DOSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that diazepam rectal gel cannot be used.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

vascepa

Products Affected

- *icosapent ethyl*
- VASCEPA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For a diagnosis of hypertriglyceridemia: Documented trial of, contraindication to, or medical reason for not using statins at maximum tolerated dose OR documented statin intolerance AND omega-3-acid ethyl esters capsule. For a diagnosis of cardiovascular risk reduction, ALL the following are required: 1) Documentation of hypertriglyceridemia greater than or equal to 150 mg/dL: 2) Documented trial of, contraindication to, or medical reason for not using statins at maximum tolerated dose for 3 months OR documented statin intolerance AND 3) Documentation of one of the following: Established atherosclerotic cardiovascular disease (e.g., coronary artery disease, cerebrovascular accident, carotid disease, peripheral artery disease) OR age greater than or equal to 50 years old with established diabetes and at least one additional risk factor for cardiovascular disease (e.g., hypertension, renal dysfunction, retinopathy, albuminuria, males age greater than or equal to 55 years old or females age greater than or equal to 65 years old).
Indications	All Medically-accepted Indications.
Off Label Uses	

ventavis

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group classification and PAH Functional Class.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

vigabatrin

Products Affected

- *vigabatrin*
- VIGADRONE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If the patient has a diagnosis of infantile spasms or West syndrome, the request will be approved. Patient must have a diagnosis of refractory complex partial seizures who is currently receiving another antiepileptic drug and the patient has experienced treatment failure from two previous formulary antiepileptic agents (lamotrigine, gabapentin, carbamazepine, topiramate, tiagabine, oxcarbazepine, levetiracetam, phenytoin, zonisamide, divalproex).
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

vmat-2 inhibitors

Products Affected

- AUSTEDO
- INGREZZA
- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If the request is for tetrabenazine, request will be approved. For Ingrezza, trial of or medical reason for not using the tetrabenazine for tardive dyskinesia. For Austedo, trial of or medical reason for not using the following if applicable for submitted diagnosis 1) Chorea associated with Huntington disease- trial of tetrabenazine. 2) Tardive dyskinesia -trial of tetrabenazine and Ingrezza. Reauthorization: Confirmation of improvement in tardive dyskinesia symptoms or chorea associated with Huntington disease symptoms.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist, clinical geneticist, or psychiatrist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

vosevi

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Labs within 3 months of request: ALT or AST, detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, or transplant specialist.
Coverage Duration	Request will be authorized for 12 weeks as per AASLD-IDSA guidance.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

white blood cell stimulators

Products Affected

- FULPHILA
- GRANIX
- LEUKINE INJECTION SOLUTION RECONSTITUTED
- NEULASTA ONPRO
- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML
- NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE
- NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE
- UDENYCA
- ZARXIO
- ZIEXTENZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For all agents, provider attests that ANC will be regularly monitored throughout the duration of therapy. For initial request for Neupogen, documentation of trial of, contraindication to, or medical reason for not using Zarxio, Nivestym, or Granix. For initial request for Neulasta, documentation of trial of, contraindication to, or medical reason for not using Fulphila, Udenyca, or Ziextenzo. Re-authorization criteria: diagnosis of chronic neutropenia or a medical reason for continued need for GCSF.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hematologist, an oncologist or an infectious disease specialist.
Coverage Duration	For new starts only: 4 months. Reauthorization until end of contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

xatmep

Products Affected

- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or rheumatologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

XELJANZ

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Trial of, contraindication to, or medical reason for not using the following if applicable for submitted diagnosis: 1) For Rheumatoid Arthritis or Psoriatic Arthritis: one DMARD (e.g. methotrexate, sulfasalazine, generic leflunomide (Arava), etc.), 2) For Ulcerative Colitis: one conventional oral therapy (e.g. azathioprine, sulfasalazine, prednisone, mesalamine products).
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

xermelo

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

xgeva

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	Patients with baseline hypocalcemia
Required Medical Information	Criteria for new starts: Serum calcium levels for all indications
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Skeletal related events and giant cell bone tumor:contract year. Malignant hypercalcemia: 4months
Other Criteria	Reauthorization criterion for skeletal related events or giant cell bone tumor:statement of continued need for use of Xgeva. Reauthorization criteria for malignant hypercalcemia: albumin-adjusted serum calcium level below 12.5mg/dl within 30 days of request and statement of continued need for Xgeva.
Indications	All Medically-accepted Indications.
Off Label Uses	

xifaxan

Products Affected

- XIFAXAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diagnosis of hepatic encephalopathy (HE): patient must have documented trial of, contraindication to, or medical reason for not using lactulose. For diagnosis of irritable bowel syndrome with diarrhea (IBSD), the patient has documented trial of, contraindication to, or medical reason for not using loperamide and dicyclomine. For diagnosis of travelers diarrhea (TD) caused by noninvasive strains of E. Coli (with no bloody stools or fever), patient must be intolerant to or must have had a trial of at least 3 days of one of the following agents: ciprofloxacin, ofloxacin, levofloxacin or azithromycin.
Age Restrictions	
Prescriber Restrictions	For hepatic encephalopathy, gastroenterologist, hepatologist. For IBS-D, gastroenterologist
Coverage Duration	For HE: contract year. For IBSD: 14 days (cannot exceed 3 courses of 14 days each). For TD: 3 days.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

xolair

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist, allergist, immunologist, or dermatologist.
Coverage Duration	Initial authorization: 6 months. Reauthorization until end of contract year.
Other Criteria	Initial criteria for moderate to severe persistent allergic asthma: 1) Evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. radioallergosorbent test) for a specific IgE or in vitro reactivity to a perennial aeroallergen, AND 2) Pretreatment serum IgE levels greater than 30 and less than 1300 IU/mL, AND 3) Symptoms are not adequately controlled with high-dose inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) for at least 3 months, or medical justification has been provided indicating why a patient is not able to utilize a high-dose inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) to treat their medical condition. Reauthorization criteria for moderate to severe persistent allergic asthma: 1) Reduction in asthma exacerbation resulting in systemic steroid use and/or hospitalization, OR 2) Reduction of rescue inhaler use, OR 3) Documentation of improvement in pulmonary function tests since baseline (prior to initiation of Xolair). Initial criteria for chronic idiopathic urticaria: 1) Patient must have inadequate symptomatic relief despite trial of two weeks of two different oral antihistamine therapies (unless contraindicated), AND 2) Patient's disease must be severe enough to warrant short term systemic corticosteroid therapy for management of urticaria. Reauthorization criteria for chronic idiopathic urticaria: 1) Continued improvement from baseline of symptoms associated with urticaria within 6 months of Xolair use.

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	

xuriden

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an endocrinologist, metabolic specialist, clinical geneticist or hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

xyrem

Products Affected

- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a sleep specialist or a neurologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For treatment of somnolence associated with narcolepsy, patient must have documentation of either trial of or a medical reason for being unable to use an approved formulary CNS stimulant (e.g. methylphenidate, modafinil, armodafinil, etc.)
Indications	All Medically-accepted Indications.
Off Label Uses	

zeposia

Products Affected

- ZEPOSIA
- ZEPOSIA 7-DAY STARTER PACK
- ZEPOSIA STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documentation showing trial of two of the following agents: Aubagio, glatiramer, or glatopa OR the patient has another documented medical reason (intolerance, hypersensitivity, etc) for not taking any of these therapies to manage their medical condition.
Indications	All Medically-accepted Indications.
Off Label Uses	

zyprexa relprevv

Products Affected

- ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION — RECONSTITUTED 210 MG, 300 MG, 405 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The member has a documented history of receiving oral olanzapine without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing one of these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

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