2019 Vantage Health Plan Medicare Formulary

Prior Authorization Criteria
Last Updated 12/1/2019

Products Affected

- *adapalene 0.1% cream*
- *adapalene 0.3% gel*
- *avita 0.025% cream*
- AZELEX 20% CREAM
- EPIDUO 0.3-2.5% GEL
- *tretinoin 0.025% cream*
- *tretinoin 0.04% gel*
- *tretinoin 0.05% gel*
- *tretinoin 0.1% gel*
- *adapalene 0.1% gel*
- *adapalene/benzoyl peroxide 0.1-2.5% gel*
- *avita 0.025% gel*
- DIFFERIN 0.1% LOTION
- *tretinoin 0.01% gel*
- *tretinoin 0.025% gel*
- *tretinoin 0.05% cream*
- *tretinoin 0.1% cream*

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance to or failure of therapy with Humira AND Enbrel. For Giant Cell Arteritis: trial and failure of Humira AND Enbrel not required. For Giant Cell Arteritis: trial and failure of corticosteroids required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ADCIRCA 20MG TAB
- *alyq 20mg tab*
- *tadalafil 20mg tab(PAH)*

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For diagnosis of Pulmonary Arterial Hypertension, trial of one (1) of the following: Letairis, Opsumit or Tracleer. For diagnosis of Persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4), trial of prior therapy is not required.

Products Affected

- AFINITOR 10MG TAB (New Starts Only)
- AFINITOR 2MG SUSP (New Starts Only)
- AFINITOR 5MG SUSP (New Starts Only)
- AFINITOR 7.5MG TAB (New Starts Only)
- AFINITOR 2.5MG TAB (New Starts Only)
- AFINITOR 3MG SUSP (New Starts Only)
- AFINITOR 5MG TAB (New Starts Only)

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

Products Affected

– ALECENSA 150MG CAP (New Starts Only)

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

Products Affected

- ALINIA 100MG/5ML SUSP
- ALINIA 500MG TAB

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

Products Affected

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

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

Products Affected

- AMPYRA 10MG ER TAB
- *dalfampridine 10mg er tab*

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

Products Affected

- ANDRODERM 2MG/24HR PATCH
- ANDRODERM 4MG/24HR PATCH
- METHITEST 10MG TAB
- METHYLTESTOSTERONE 10MG CAP
- *testosterone 1% (25mg) gel*
- *testosterone 1% (50mg) gel*
- *testosterone 1% gel pump*
- *testosterone 1.62% (1.25gm) gel*
- *testosterone 1.62% (2.5gm) gel*
- *testosterone 1.62% gel pump*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two morning testosterone levels fall below the normal range for a healthy adult male. For patients on testosterone replacement therapy, documentation of at least one (1) morning testosterone level from the last 12 months is required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

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

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

Products Affected

– ARCALYST 220MG INJ

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

Products Affected

– ARIKAYCE 70.3MG/ML INH SOLN

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

Products Affected

- *fondaparinux sodium 12.5mg/ml (0.4ml) syringe*
- *fondaparinux sodium 12.5mg/ml (0.8ml) syringe*
- *fondaparinux sodium 12.5mg/ml (0.6ml) syringe*
- *fondaparinux sodium 5mg/ml syringe*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Body weight less than 50 kg (venous thromboembolism prophylaxis only).
Required Medical Info	If prescribed for acute DVT, patient must have a trial with or contraindication to enoxaparin. For all other FDA-approved indications, trial of enoxaparin not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *aripiprazole 10mg odt (New Starts Only)*
- *aripiprazole 1mg/ml oral soln (New Starts Only)*
- FANAPT 12MG TAB (New Starts Only)
- FANAPT 2MG TAB (New Starts Only)
- FANAPT 6MG TAB (New Starts Only)
- FANAPT TITRATION PACK (New Starts Only)
- LATUDA 20MG TAB (New Starts Only)
- LATUDA 60MG TAB (New Starts Only)
- *paliperidone 1.5mg er tab (New Starts Only)*
- *paliperidone 6mg er tab (New Starts Only)*
- REXULTI 0.25MG TAB (New Starts Only)
- REXULTI 1MG TAB (New Starts Only)
- REXULTI 3MG TAB (New Starts Only)
- SAPHRIS 10MG SL TAB (New Starts Only)
- SAPHRIS 5MG SL TAB (New Starts Only)
- VRAYLAR 1.5MG CAP (New Starts Only)
- VRAYLAR 4.5MG CAP (New Starts Only)
- *aripiprazole 15mg odt (New Starts Only)*
- FANAPT 10MG TAB (New Starts Only)
- FANAPT 1MG TAB (New Starts Only)
- FANAPT 4MG TAB (New Starts Only)
- FANAPT 8MG TAB (New Starts Only)
- LATUDA 120MG TAB (New Starts Only)
- LATUDA 40MG TAB (New Starts Only)
- LATUDA 80MG TAB (New Starts Only)
- *paliperidone 3mg er tab (New Starts Only)*
- *paliperidone 9mg er tab (New Starts Only)*
- REXULTI 0.5MG TAB (New Starts Only)
- REXULTI 2MG TAB (New Starts Only)
- REXULTI 4MG TAB (New Starts Only)
- SAPHRIS 2.5MG SL TAB (New Starts Only)
- VRAYLAR 1.5/3MG MIXED PACK (New Starts Only)
- VRAYLAR 3MG CAP (New Starts Only)
- VRAYLAR 6MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed or was intolerant to 2 of the following for each indication: Bipolar Disorder: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. Schizophrenia: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. Irritability with Autistic Disorder: aripiprazole, risperidone. Patient has tried and failed or was intolerant to 1 of the following for each indication: Bipolar Depression: olanzapine. Major Depressive Disorder: aripiprazole. Tourette Syndrome: aripiprazole. Acute Manic/Mixed Episodes with Bipolar Disorder: aripiprazole. No trials required for the following indications: Schizoaffective Disorder.
Age Restrictions	

Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– AURYXIA 210MG TAB

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has chorea due to Huntington's Disease. Patient has intolerance to or failure of therapy with tetrabenazine.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist or Psychiatrist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

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

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

Products Affected

- BAXDELA 450MG TAB

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

Products Affected

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

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

Products Affected

- BENZNIDAZOLE 100MG TAB
- BENZNIDAZOLE 12.5MG TAB

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

Products Affected

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

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

Products Affected

– BRAFTOVI 75MG CAP (New Starts Only)

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

Products Affected

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

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

Products Affected

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

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

Products Affected

– CALQUENCE 100MG CAP (New Starts Only)

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

Products Affected

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

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

Products Affected

- CARBAGLU 200MG SUSP

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

Products Affected

– CAYSTON 75MG INH SOLN

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

Products Affected

- CERDELGA 84MG CAP

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

Products Affected

– CESAMET 1MG CAP

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

Products Affected

– EMGALITY 100MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of episodic cluster headache AND has tried and failed verapamil.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with a Neurologist or Headache Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Headache specialist defined as a member of the United Council for Neurologic Subspecialties, American Headache Society, National Headache Foundation, or International Headache Society OR has a certificate of added qualification in headache medicine or by the American Board of Headache Management.

Products Affected

- AIMOVIG 140MG/ML AUTO-INJECTOR
- AIMOVIG 70MG/ML AUTO-INJECTOR
- EMGALITY 120MG/ML AUTO-INJECTOR
- EMGALITY 120MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has greater than or equal to 4 migraine days per month for the previous 3 months or longer AND has tried and failed a 3-month or greater trial of 2 of the 3 following drug classes: anticonvulsants, vasoactive agents, antidepressants.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with a Neurologist OR headache specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Headache specialist defined as a member of the United Council for Neurologic Subspecialties, American Headache Society, National Headache Foundation, or International Headache Society OR has a certificate of added qualification in headache medicine or by the American Board of Headache Management.

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Rheumatoid Arthritis (RA): Intolerance to or failure of therapy with Humira AND Enbrel. For Ankylosing Spondylitis (AS): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Cosentyx. For Psoriatic Arthritis and Plaque Psoriasis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Crohn's Disease: Intolerance to or failure of therapy with Humira.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Crohn's Disease : Prescribed by, or in consultation with a Gastroenterology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– COLCHICINE 0.6MG TAB

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	The patient is on a maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication, or a hypersensitivity to beta blocker.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- COSENTYX 150MG/ML AUTO-INJECTOR
- COSENTYX 150MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Plaque Psoriasis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR soriatane. For Ankylosing Spondylitis (AS) or Psoriatic Arthritis: Requires failure of, or intolerance to methotrexate OR sulfasalazine. (Trial of methotrexate or sulfasalazine not required for AS with predominant axial involvement).
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with Rheumatology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– COTELLIC 20MG TAB (New Starts Only)

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

Products Affected

– CYSTARAN 0.44% OPHTH SOLN

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- DUPIXENT 200MG/ML PF SYR
- DUPIXENT 300MG/2ML PF SYR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Atopic Dermatitis: Intolerance to, or failure of therapy of two (2) of the following: a medium to very high potency topical steroid, a topical calcineurin inhibitor OR an oral immunosuppressant. For Asthma: Prescriber attests that member has a history, within the last year, of at least 1 asthma exacerbation requiring one of the following: treatment with systemic corticosteroids OR emergency department visit OR hospitalization.
Age Restrictions	For Atopic Dermatitis: Member must be 12 years of age or older. For Asthma: Member must be 12 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with an Allergist, Immunologist, Pulmonologist, or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For atopic dermatitis: Member has moderate to severe atopic dermatitis defined as: 1) body surface area involvement of 10 percent or more OR chart documentation of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. 2) At least two (2) of the following: intractable pruritus (itching), cracking and oozing/bleeding of skin, OR impaired activities of daily living. For asthma: Member has moderate to severe asthma with an eosinophilic phenotype (documented baseline blood eosinophil concentration greater than or equal to 150 cells/mL) OR member has oral corticosteroid-dependent asthma.

Products Affected

- ENBREL 25MG INJ
- ENBREL 50MG/ML CARTRIDGE
- ENBREL 50MG/ML SYRINGE
- ENBREL 25MG/0.5ML SYRINGE
- ENBREL 50MG/ML SURECLICK INJ

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

Products Affected

– ENDARI 5000MG POWDER FOR ORAL SOLN

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

Products Affected

- EPCLUSA 400-100MG TAB
- SOFOSBUVIR/VELPATASVIR 400-100MG TAB

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

Products Affected

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

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

Products Affected

– ERIVEDGE 150MG CAP (New Starts Only)

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

Products Affected

– ERLEADA 60MG TAB (New Starts Only)

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

Products Affected

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

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

Products Affected

- FERRIPROX 1000MG TAB
- FERRIPROX 500MG TAB
- FERRIPROX 100MG/ML ORAL SOLN

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

Products Affected

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

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

Products Affected

- DICLOFENAC EPOLAMINE 1.3% PATCH
- FLECTOR 1.3% PATCH

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

Products Affected

– FORTEO 600MCG/2.4ML PEN INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has had at least 1 fracture, OR member has BMD screening results of -2.5 or below, OR member has previously used and failed a bisphosphonate.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

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

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

Products Affected

- GALAFOLD 123MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation that member has an amenable glactosidase alpha gene (GLA) variant.
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with a Medical Geneticist or a prescriber specialized in the treatment of Fabry disease.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- GARDASIL 9 INJ
- GARDASIL 9 SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	PA not required for members age 9-45.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– GATTEX 5MG INJ

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- BERINERT 500UNIT INJ
- FIRAZYR 30MG/3ML SYRINGE
- HAEGARDA 3000UNT INJ
- RUCONEST 2100UNIT INJ
- CINRYZE 500UNIT INJ
- HAEGARDA 2000UNT INJ
- *icatibant 10mg/ml syringe*
- TAKHZYRO 300MG/2ML INJ

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

Products Affected

– HETLIOZ 20MG CAP

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

Products Affected

- ALORA 0.025MG/24HR PATCH
- ALORA 0.05MG/24HR PATCH
- ALORA 0.075MG/24HR PATCH
- ALORA 0.1MG/24HR PATCH
- *amitriptyline 12.5mg/chlordiazepoxide 5mg tab (New Starts Only)*
- *amitriptyline 25mg/chlordiazepoxide 10mg tab (New Starts Only)*
- *benztropine mesylate 0.5mg tab*
- *benztropine mesylate 1mg tab*
- *benztropine mesylate 2mg tab*
- BUTISOL 30MG TAB
- *chlordiazepoxide 10mg cap*
- *chlordiazepoxide 25mg cap*
- *chlordiazepoxide 5mg cap*
- CHLORZOXAZONE 500MG TAB
- CLIMARA PRO 0.045-0.015MG PATCH
- *clonazepam 0.125mg odt (New Starts Only)*
- *clonazepam 0.25mg odt (New Starts Only)*
- *clonazepam 0.5mg odt (New Starts Only)*
- *clonazepam 0.5mg tab (New Starts Only)*
- *clonazepam 1mg odt (New Starts Only)*
- *clonazepam 1mg tab (New Starts Only)*
- *clonazepam 2mg odt (New Starts Only)*
- *clonazepam 2mg tab (New Starts Only)*
- *clorazepate dipotassium 15mg tab (New Starts Only)*
- *clorazepate dipotassium 3.75mg tab (New Starts Only)*
- *clorazepate dipotassium 7.5mg tab (New Starts Only)*
- COMBIPATCH 0.05-0.14MG PATCH
- COMBIPATCH 0.05-0.25MG PATCH
- *cyclobenzaprine 10mg tab*
- *cyclobenzaprine 5mg tab*
- *cyclobenzaprine 7.5mg tab*
- *diazepam 10mg tab (New Starts Only)*
- DIAZEPAM 1MG/ML ORAL SOLN (New Starts Only)
- *diazepam 2mg tab (New Starts Only)*
- *diazepam 5mg tab (New Starts Only)*
- *diazepam 5mg/ml oral soln (New Starts Only)*
- *dotti 0.025mg/24hr patch*
- *dotti 0.0375mg/24hr patch*
- *dotti 0.05mg/24hr patch*
- *dotti 0.075mg/24hr patch*
- *dotti 0.1mg/24hr patch*
- ERGOLOID MESYLATES 1MG TAB
- *estazolam 1mg tab*
- *estazolam 2mg tab*
- *estradiol 0.00104mg/hr twice weekly patch*
- *estradiol 0.00104mg/hr weekly patch*
- *estradiol 0.00156mg/hr twice weekly patch*
- *estradiol 0.00156mg/hr weekly patch*
- *estradiol 0.00208mg/hr twice weekly patch*
- *estradiol 0.00208mg/hr weekly patch*
- *estradiol 0.0025mg/hr weekly patch*
- *estradiol 0.00312mg/hr weekly patch*
- *estradiol 0.00313mg/hr twice weekly patch*
- *estradiol 0.00417mg/hr twice weekly patch*
- *estradiol 0.00417mg/hr weekly patch*
- *estradiol 0.5mg tab*
- *estradiol 1mg tab*
- *estradiol 2mg tab*

- *eszopiclone 1mg tab*
- eszopiclone 2mg tab
- *eszopiclone 3mg tab*
- *glyburide 1.25mg/metformin 250mg tab*
- *glyburide 2.5mg/metformin 500mg tab*
- *glyburide 5mg/metformin 500mg tab*
- *lorazepam 0.5mg tab*
- *lorazepam 1mg tab*
- *lorazepam 2mg tab*
- *lorazepam 2mg/ml conc*
- MENOSTAR 14MCG/24HR PATCH
- MINIVELLE 0.025MG/24HR PATCH
- MINIVELLE 0.0375MG/24HR PATCH
- MINIVELLE 0.05MG/24HR PATCH
- MINIVELLE 0.075MG/24HR PATCH
- MINIVELLE 0.1MG/24HR PATCH
- *orphenadrine citrate 100mg er tab*
- *oxazepam 10mg cap*
- *oxazepam 15mg cap*
- OXAZEPAM 30MG CAP
- *thioridazine 100mg tab (New Starts Only)*
- *thioridazine 10mg tab (New Starts Only)*
- *thioridazine 25mg tab (New Starts Only)*
- *thioridazine 50mg tab (New Starts Only)*
- TRIAZOLAM 0.125MG TAB
- *triazolam 0.25mg tab*
- *trihexyphenidyl 2mg tab*
- *trihexyphenidyl 5mg tab*
- *zaleplon 10mg cap*
- *zaleplon 5mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	The prescriber has documented the indication for the continued use of the high risk medication with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. The physician must document the ongoing monitoring plan for the agent AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.
Age Restrictions	PA applies to members 65 years or older.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- JUXTAPID 10MG CAP
- JUXTAPID 20MG CAP
- JUXTAPID 30MG CAP
- JUXTAPID 40MG CAP
- JUXTAPID 5MG CAP
- JUXTAPID 60MG CAP

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

Products Affected

- *amitriptyline 100mg tab (New Starts Only)*
- *amitriptyline 150mg tab (New Starts Only)*
- *amitriptyline 50mg tab (New Starts Only)*
- AMOXAPINE 100MG TAB (New Starts Only)
- AMOXAPINE 25MG TAB (New Starts Only)
- *clomipramine 25mg cap (New Starts Only)*
- *clomipramine 75mg cap (New Starts Only)*
- *desipramine 10mg tab (New Starts Only)*
- *desipramine 25mg tab (New Starts Only)*
- *desipramine 75mg tab (New Starts Only)*
- *doxepin 10mg cap (New Starts Only)*
- *doxepin 150mg cap (New Starts Only)*
- *doxepin 50mg cap (New Starts Only)*
- *imipramine 10mg tab (New Starts Only)*
- *imipramine 50mg tab (New Starts Only)*
- *imipramine pamoate 125mg cap (New Starts Only)*
- *imipramine pamoate 75mg cap (New Starts Only)*
- *nortriptyline 25mg cap (New Starts Only)*
- *nortriptyline 50mg cap (New Starts Only)*
- *paroxetine 10mg tab (New Starts Only)*
- *paroxetine 20mg tab (New Starts Only)*
- *paroxetine 30mg tab (New Starts Only)*
- *paroxetine 40mg tab (New Starts Only)*
- PEXEVA 10MG TAB (New Starts Only)
- PEXEVA 30MG TAB (New Starts Only)
- *protriptyline 10mg tab (New Starts Only)*
- *trimipramine 100mg cap (New Starts Only)*
- *trimipramine 50mg cap (New Starts Only)*
- *amitriptyline 10mg tab (New Starts Only)*
- *amitriptyline 25mg tab (New Starts Only)*
- *amitriptyline 75mg tab (New Starts Only)*
- AMOXAPINE 150MG TAB (New Starts Only)
- AMOXAPINE 50MG TAB (New Starts Only)
- *clomipramine 50mg cap (New Starts Only)*
- *desipramine 100mg tab (New Starts Only)*
- *desipramine 150mg tab (New Starts Only)*
- *desipramine 50mg tab (New Starts Only)*
- *doxepin 100mg cap (New Starts Only)*
- *doxepin 10mg/ml oral soln (New Starts Only)*
- *doxepin 25mg cap (New Starts Only)*
- *doxepin 75mg cap (New Starts Only)*
- *imipramine 25mg tab (New Starts Only)*
- *imipramine pamoate 100mg cap (New Starts Only)*
- *imipramine pamoate 150mg cap (New Starts Only)*
- *nortriptyline 10mg cap (New Starts Only)*
- *nortriptyline 2mg/ml oral soln (New Starts Only)*
- *nortriptyline 75mg cap (New Starts Only)*
- *paroxetine 12.5mg er tab (New Starts Only)*
- *paroxetine 25mg er tab (New Starts Only)*
- *paroxetine 37.5mg er tab (New Starts Only)*
- PAXIL 10MG/5ML SUSP (New Starts Only)
- PEXEVA 20MG TAB (New Starts Only)
- PEXEVA 40MG TAB (New Starts Only)
- *protriptyline 5mg tab (New Starts Only)*
- *trimipramine 25mg cap (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires trial and failure of one of the following: SSRI (not including paroxetine), SNRI, OR bupropion. For diagnosis of nocturnal enuresis, trial and failure of other agents not required.
Age Restrictions	PA applies to members 65 years or older.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *disopyramide 100mg cap*
- NORPACE 100MG ER CAP
- *disopyramide 150mg cap*
- NORPACE 150MG ER CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires trial and failure of one of the following: beta-blocker, calcium channel blockers, OR flecainide.
Age Restrictions	PA applies to members 65 years or older.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- HUMIRA 10MG/0.1ML SYRINGE
- HUMIRA 10MG/0.2ML SYRINGE
- HUMIRA 20MG/0.2ML SYRINGE
- HUMIRA 20MG/0.4ML SYRINGE
- HUMIRA 40MG/0.4ML AUTO-INJECTOR
- HUMIRA 40MG/0.4ML SYRINGE
- HUMIRA 40MG/0.8ML AUTO-INJECTOR
- HUMIRA 40MG/0.8ML SYRINGE
- HUMIRA PEDIATRIC CROHN'S STARTER PACK (3) 40MG/0.8ML IN
- HUMIRA PEDIATRIC CROHN'S STARTER PACK (3) 80MG/0.8ML IN
- HUMIRA PEDIATRIC CROHN'S STARTER PACK (6) 40MG/0.8ML IN
- HUMIRA PEDIATRIC CROHN'S STARTER PACK SYRINGE (2) 40M
- HUMIRA PEN - CROHN'S STARTER PACK 40MG/0.8ML INJ
- HUMIRA PEN - CROHN'S STARTER PACK 80MG/0.8ML INJ
- HUMIRA PEN - PSORIASIS STARTER PACK 40MG/0.8ML INJ
- HUMIRA PEN - PSORIASIS STARTER PACK 80MG/0.8ML INJ

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

Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- *imatinib 100mg tab (New Starts Only)*
- *imatinib 400mg tab (New Starts Only)*

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

Products Affected

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

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

Products Affected

– INCRELEX 40MG/4ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the long-term treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency (primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

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

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

Products Affected

– INREBIC 100MG CAP (New Starts Only)

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

Products Affected

- ESBRIET 267MG CAP
- ESBRIET 801MG TAB
- OFEV 150MG CAP
- ESBRIET 267MG TAB
- OFEV 100MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Definitive diagnosis of idiopathic pulmonary fibrosis defined by the following: No known cause of lung fibrosis AND one of the following: A. Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) B. High-resolution computed tomography indicates definite UIP pattern C. High-resolution computed tomography indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Will not be used in combination with other medications used to treat IPF.

Products Affected

– IRESSA 250MG TAB (New Starts Only)

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

Products Affected

- *itraconazole 100mg cap*
- *itraconazole 10mg/ml oral soln*
- SPORANOX 10MG/ML ORAL SOLN

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

Products Affected

- FLEBOGAMMA 10% INJ
- GAMMAGARD 2.5GM/25ML INJ
- GAMMAKED 1GM/10ML INJ
- GAMMAPLEX 10GM/200ML INJ
- GAMMAPLEX 5GM/50ML INJ
- OCTAGAM 25GM/500ML INJ
- PANZYGA 10GM/100ML IV SOLN
- PANZYGA 2.5GM/25ML IV SOLN
- PANZYGA 30GM/300ML IV SOLN
- PRIVIGEN 20GM/200ML INJ
- GAMMAGARD 10GM INJ
- GAMMAGARD 5GM INJ
- GAMMAPLEX 10GM/100ML INJ
- GAMMAPLEX 20GM/200ML INJ
- GAMUNEX 1GM/10ML INJ
- OCTAGAM 2GM/20ML INJ
- PANZYGA 1GM/10ML IV SOLN
- PANZYGA 20GM/200ML IV SOLN
- PANZYGA 5GM/50ML IV SOLN

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- KEVZARA 150MG/1.14ML PF INJ
- KEVZARA 200MG/1.14ML PF INJ

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

Products Affected

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

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

Products Affected

– KORLYM 300MG TAB

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

Products Affected

- KUVAN 100MG POWDER FOR ORAL SOLN
- KUVAN 100MG TAB
- KUVAN 500MG POWDER FOR ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuing therapy the patient must have shown a 20% drop in Phenylalanine levels after 2 months of Kuvan treatment.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Medical Geneticist or Metabolic Physician.
Coverage Duration	Initial approval of 3 months, then if critieria is met, approved for the rest of the contract year.
Other Criteria	

Products Affected

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

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

Products Affected

- *ambrisentan 10mg tab*
- LETAIRIS 10MG TAB
- *ambrisentan 5mg tab*
- LETAIRIS 5MG TAB

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

Products Affected

– LEUKINE 250MCG INJ

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

Products Affected

- *lidocaine 4% topical soln*
- *lidocaine/prilocaine 2.5-2.5% cream*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	6 months
Other Criteria	

Products Affected

– *lidocaine 5% patch*

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

Products Affected

– *lidocaine 5% ointment*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial and failure of topical lidocaine 2% gel/jelly.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- LINZESS 145MCG CAP
- LINZESS 72MCG CAP
- LINZESS 290MCG CAP

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- MAVYRET 100-40MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments.
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with a Gastroenterologist, Hepatologist, Infectious Disease Physician or Transplant Physician.
Coverage Duration	Coverage duration of 8 to 16 weeks. Applied consistent with current AASLD-IDSA guidance.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

– MEKTOVI 15MG TAB (New Starts Only)

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

Products Affected

- MOVANTIK 12.5MG TAB
- MOVANTIK 25MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Initial Therapy: Member must meet all criteria. 1. Opioid-induced constipation. 2. Trial and failure of polyethylene glycol (Miralax/Glycolax).
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ABELCET 5MG/ML INJ
- *acetylcysteine 20% inh soln*
- *albuterol 0.21mg/ml (0.63mg/3ml) inh soln*
- *albuterol 0.83mg/ml (0.083%) inh soln*
- AMBISOME 50MG INJ
- AMINOSYN-PF 10% SULFITE-FREE INJ
- AMPHOTERICIN B 50MG INJ
- *aprepitant 125mg/80mg pack*
- *aprepitant 80mg cap*
- ARANESP 100MCG/ML INJ
- ARANESP 150MCG/0.3ML SYRINGE
- ARANESP 200MCG/ML INJ
- ARANESP 25MCG/ML INJ
- ARANESP 300MCG/ML INJ
- ARANESP 40MCG/ML INJ
- ARANESP 60MCG/0.3ML SYRINGE
- ASTAGRAF 0.5MG XL CAP
- ASTAGRAF 5MG XL CAP
- AZASAN 75MG TAB
- BROVANA 15MCG/2ML INH SOLN
- *budesonide 0.25mg/ml inh soln*
- *calcitriol 0.00025mg cap*
- *calcitriol 0.001mg/ml oral soln*
- *cinacalcet 60mg tab*
- CLINIMIX 4.25/10 INJ
- CLINIMIX 4.25/5 INJ
- CLINIMIX 5/20 INJ
- CLINIMIX E 2.75/5 INJ
- CLINIMIX E 4.25/5 INJ
- *acetylcysteine 10% inh soln*
- *acyclovir 50mg/ml inj*
- *albuterol 0.417mg/ml (1.25mg/3ml) inh soln*
- *albuterol 1mg/ml (0.5%) inh soln*
- AMINOSYN II 10% INJ
- AMINOSYN-PF 7% INJ
- *aprepitant 125mg cap*
- *aprepitant 40mg cap*
- ARANESP 100MCG/0.5ML SYRINGE
- ARANESP 10MCG/0.4ML SYRINGE
- ARANESP 200MCG/0.4ML SYRINGE
- ARANESP 25MCG/0.42ML SYRINGE
- ARANESP 300MCG/0.6ML SYRINGE
- ARANESP 40MCG/0.4ML SYRINGE
- ARANESP 500MCG/ML SYRINGE
- ARANESP 60MCG/ML INJ
- ASTAGRAF 1MG XL CAP
- AZASAN 100MG TAB
- *azathioprine 50mg tab*
- *budesonide 0.125mg/ml inh soln*
- *budesonide 0.5mg/ml inh soln*
- *calcitriol 0.0005mg cap*
- *cinacalcet 30mg tab*
- *cinacalcet 90mg tab*
- CLINIMIX 4.25/25 INJ
- CLINIMIX 5/15 INJ
- CLINIMIX 5/25 INJ
- CLINIMIX E 4.25/10 INJ
- CLINIMIX E 5/15 INJ

- CLINIMIX E 5/20 INJ
- *cromolyn sodium 10mg/ml inh soln*
- CYCLOPHOSPHAMIDE 50MG CAP
- *cyclosporine 25mg cap*
- *cyclosporine modified 100mg/ml oral soln*
- CYCLOSPORINE MODIFIED 50MG CAP
- *doxercalciferol 0.0005mg cap*
- *doxercalciferol 0.0025mg cap*
- *duramorph 1mg/ml inj*
- ENGERIX-B 20MCG/ML SYRINGE
- ENVARSUS 1MG ER TAB
- EPOGEN 10000UNIT/ML INJ
- EPOGEN 2000UNIT/ML INJ
- EPOGEN 4000UNIT/ML INJ
- *gengraf 100mg cap*
- *gengraf 25mg cap*
- *heparin sodium porcine 10000unit/ml inj*
- *heparin sodium porcine 20000unit/ml inj*
- HEPATAMINE 8% INJ
- *intralipid 200mg/ml inj*
- *ipratropium bromide 0.02% inh soln*
- *levalbuterol 0.31mg inh soln*
- *levalbuterol 1.25mg inh soln*
- *levocarnitine 100mg/ml oral soln*
- *mycophenolate mofetil 200mg/ml susp*
- *mycophenolate mofetil 500mg tab*
- *mycophenolic acid 360mg dr tab*
- NEPHRAMINE 5.4% INJ
- *ondansetron 0.8mg/ml oral soln*
- *ondansetron 4mg odt*
- *clinisol 15% inj*
- CYCLOPHOSPHAMIDE 25MG CAP
- *cyclosporine 100mg cap*
- *cyclosporine modified 100mg cap*
- *cyclosporine modified 25mg cap*
- DIPHTHERIA/TETANUS TOXOID INJ
- *doxercalciferol 0.001mg cap*
- *duramorph 0.5mg/ml inj*
- ENGERIX-B 10MCG/0.5ML SYRINGE
- ENVARSUS 0.75MG ER TAB
- ENVARSUS 4MG ER TAB
- EPOGEN 20000UNIT/ML INJ
- EPOGEN 3000UNIT/ML INJ
- FREAMINE 6.9% INJ
- *gengraf 100mg/ml oral soln*
- *granisetron 1mg tab*
- *heparin sodium porcine 1000unit/ml inj*
- *heparin sodium porcine 5000unit/ml inj*
- IMOVAX 2.5UNIT/ML INJ
- INTRALIPID 30% INJ
- *ipratropium/albuterol 0.5-2.5mg/3ml inh soln*
- *levalbuterol 0.63mg inh soln*
- *levalbuterol 2.5mg inh soln*
- *levocarnitine 330mg tab*
- *mycophenolate mofetil 250mg cap*
- *mycophenolic acid 180mg dr tab*
- NEBUPENT 300MG INH SOLN
- *nutrilipid 20% iv soln*
- *ondansetron 24mg tab*
- *ondansetron 4mg tab*

- *ondansetron 8mg odt*
- *ondansetron 8mg tab*
- *paricalcitol 0.001mg cap*
- *paricalcitol 0.002mg cap*
- *paricalcitol 0.004mg cap*
- PERFOROMIST 20MCG/2ML INH SOLN
- *plenamine 15% inj*
- PREMASOL 10% INJ
- *premasol 6% inj*
- PROCALAMINE 3% INJ
- PROCRIT 10000UNIT/ML INJ
- PROCRIT 20000UNIT/ML INJ
- PROCRIT 2000UNIT/ML INJ
- PROCRIT 3000UNIT/ML INJ
- PROCRIT 40000UNIT/ML INJ
- PROCRIT 4000UNIT/ML INJ
- PROGRAF 0.2MG GRANULES PACKET
- PROGRAF 1MG GRANULES PACKET
- PROSOL 20% INJ
- PULMOZYME 1MG/ML INH SOLN
- RABAVERT 2.5UNIT/ML INJ
- RAPAMUNE 1MG/ML ORAL SOLN
- RECOMBIVAX 10MCG/ML SYRINGE
- RECOMBIVAX 40MCG/ML INJ
- RECOMBIVAX 5MCG/0.5ML SYRINGE
- RECOMBIVAX HB 10MCG/ML INJ
- RETACRIT 10000UNIT/ML INJ
- RETACRIT 2000UNIT/ML INJ
- RETACRIT 3000UNIT/ML INJ
- RETACRIT 40000UNIT/ML INJ
- RETACRIT 4000UNIT/ML INJ
- SANDIMMUNE 100MG/ML ORAL SOLN
- SENSIPAR 30MG TAB
- SENSIPAR 60MG TAB
- SENSIPAR 90MG TAB
- *sirolimus 0.5mg tab*
- *sirolimus 1mg tab*
- *sirolimus 1mg/ml oral soln*
- *sirolimus 2mg tab*
- *tacrolimus 0.5mg cap*
- *tacrolimus 1mg cap*
- *tacrolimus 5mg cap*
- TENIVAC SYRINGE
- TETANUS/DIPHTHERIA TOXOID INJ
- TRAVASOL 10% INJ
- TROPHAMINE 10% INJ
- VARUBI 90MG TAB
- ZORTRESS 0.25MG TAB
- ZORTRESS 0.5MG TAB
- ZORTRESS 0.75MG TAB
- ZORTRESS 1MG TAB

PA Criteria	Criteria Details
Covered Uses	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	
Other Criteria	

Products Affected

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

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

Products Affected

– NERLYNX 40MG TAB (New Starts Only)

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

Products Affected

– NEXAVAR 200MG TAB (New Starts Only)

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

Products Affected

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

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

Products Affected

- NORTHERA 100MG CAP
- NORTHERA 200MG CAP
- NORTHERA 300MG CAP

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

Products Affected

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

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

Products Affected

– NUBEQA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For nonmetastatic castration-resistant prostate cancer (nmCRPC), failure of or intolerance to apalutamide (Erleada) required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NUCALA 100MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Asthma diagnosis: Peripheral blood eosinophil count of greater than or equal to 150 cells per microliter. History of 2 or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s). For eosinophilic granulomatosis with polyangiitis (EGPA), confirmation of diagnosis required.
Age Restrictions	Member must be 12 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with an Allergy Specialist, Immunologist, or Pulmonary Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NUEDEXTA 20-10MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of structural neurological condition as the cause of pseudobulbal affect AND disease severity demonstrated by a score of 13 or greater on the Center for Neurologic Study Lability Scale (CNS-LS).
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Member has tried and failed an SSRI.

Products Affected

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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of narcolepsy, OR obstructive sleep apnea/hypopnea syndrome, OR shift work sleep disorder.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- OCALIVA 10MG TAB
- OCALIVA 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hepatologist or Gastroenterologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For use in treatment of primary biliary cholangitis, patient has had an inadequate response to a year of therapy with ursodiol or experienced intolerance to ursodiol.

Products Affected

– ODOMZO 200MG CAP (New Starts Only)

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

Products Affected

- ONFI 10MG TAB (New Starts Only)
- ONFI 20MG TAB (New Starts Only)
- ONFI 2.5MG/ML SUSP (New Starts Only)

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

Products Affected

- OPSUMIT 10MG TAB

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

Products Affected

- ABSTRAL 100MCG SL TAB
- ABSTRAL 200MCG SL TAB
- ABSTRAL 300MCG SL TAB
- ABSTRAL 400MCG SL TAB
- ABSTRAL 600MCG SL TAB
- ABSTRAL 800MCG SL TAB
- FENTANYL 0.1MG BUCCAL TAB
- FENTANYL 0.2MG BUCCAL TAB
- *fentanyl 0.2mg lozenge*
- FENTANYL 0.4MG BUCCAL TAB
- *fentanyl 0.4mg lozenge*
- FENTANYL 0.6MG BUCCAL TAB
- *fentanyl 0.6mg lozenge*
- FENTANYL 0.8MG BUCCAL TAB
- *fentanyl 0.8mg lozenge*
- *fentanyl 1.2mg lozenge*
- *fentanyl 1.6mg lozenge*
- FENTORA 100MCG BUCCAL TAB
- FENTORA 200MCG BUCCAL TAB
- FENTORA 400MCG BUCCAL TAB
- FENTORA 600MCG BUCCAL TAB
- FENTORA 800MCG BUCCAL TAB
- LAZANDA 100MCG/ACT NASAL SPRAY
- LAZANDA 300MCG/ACT NASAL SPRAY
- LAZANDA 400MCG/ACT NASAL SPRAY

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- ORFADIN 10MG CAP
- ORFADIN 2MG CAP
- ORFADIN 20MG CAP
- ORFADIN 5MG CAP

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

Products Affected

- ORILISSA 150MG TAB
- ORILISSA 200MG TAB

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Lung function (FEV1, ppFEV1), 2) BMI, 3) Pulmonary exacerbation history to be collected initially and at continuation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist.
Coverage Duration	Initial and continuation approval of 6 months to assess required medical info.
Other Criteria	

Products Affected

– OSPHENA 60MG TAB

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Psoriatic Arthritis requires intolerance to or failure of therapy with methotrexate (at least 20mg/wk). For Plaque Psoriasis: Failure of, or intolerance to, methotrexate at a dose of 15mg/week or failure of, or intolerance to, soriatane.
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- PRALUENT 150MG/ML AUTO-INJECTOR
- REPATHA 120MG/ML CARTRIDGE
- REPATHA 140MG/ML SYRINGE
- PRALUENT 75MG/ML AUTO-INJECTOR
- REPATHA 140MG/ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initiation of therapy patient must: A) Have one of the following conditions: 1) prior clinical atherosclerotic cardiovascular disease (ASCVD) (see Other Criteria), 2) heterozygous familial hypercholesterolemia (HeFH) (see Other Criteria) 3) homozygous familial hypercholesterolemia (HoFH) (see Other Criteria) or 4) Primary hyperlipidemia other than HeFH and HoFH (see Other Criteria) AND B) Current LDL-C level is over 100 mg/dL or over 70 mg/dL with diabetes, AND one of the following requirements is met: 1) patient has been treated for 8 weeks or more with a high intensity statin (atorvastatin 40mg or greater OR rosuvastatin 20mg or greater), OR 2) patient is intolerant to statins demonstrated by the failure of 2 statins, including an attempt with a low- or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin). Criteria B) not required for HoFH. For continuation of therapy, patient must: A) have one of the following conditions: 1) prior clinical ASCVD (see Other Criteria), 2) HeFH (see Other Criteria), 3) HoFH (see Other Criteria), or 4) Primary hyperlipidemia other than HeFH and HoFH (see Other Criteria) AND B) demonstrate a reduction of LDL-C on PCSK9 inhibitor therapy.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with a Cardiologist, Lipidologist, or Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Clinical ASCVD defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure, prior stroke or transient ischemic attack, or peripheral arterial disease of presumed atherosclerotic origin. Diagnosis of HeFH must be confirmed by one of the following: 1) DNA-based evidence of mutation in the LDLR, Apo B, OR PCSK9 gain of function mutation, 2) Untreated LDL-C greater than 190 mg/dl AND tendon xanthomas in patient or first/second degree relative, 3) Untreated LDL-C greater than 190 mg/dl AND either first degree relative less than 60 years of age or second degree relative less than 50 years of age with premature heart disease, OR 4) untreated LDL-C greater than 190 mg/dl AND first or second degree relative with total cholesterol greater than 290 mg/dL. Diagnosis of HoFH confirmed by the following: 1) two parents diagnosed with HeFH OR genetic confirmation of LDL

	receptor mutation, AND 2) untreated total cholesterol greater 290 mg/dL or LDL-C greater 190 mg/dL, AND 3) either xanthomas present at 10 years of age or younger OR atherosclerotic disease at 20 years of age or younger. Diagnosis of primary hyperlipidemia (other than HeFH and HoFH) includes documentation of one of the following subtypes: Familial hyperchylomicronemia or Buerger-Gruetz Syndrome, Familial Combined Hyperlipidemia, Familial dysbetalipoproteinemia, Familial Triglyceridemia, Endogenous Hypertriglyceridemia.

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of HR +/HER2- and PIK3CA-mutation: Used in combination with fulvestrant: Used following progession on or after an endocrine-based therapy.
Age Restrictions	
Prescriber Restriction	Prescribed by Hematologist or Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

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

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

Products Affected

- PREVYMIS 240MG TAB
- PREVYMIS 480MG TAB

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- QBRELIS 1MG/ML ORAL SOLN

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

Products Affected

- RAVICTI 1.1GM/ML ORAL SOLN

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the treatment of opioid-induced constipation (OIC) in adults with advanced illness who are receiving palliative care when response to laxative therapy has not been sufficient, member must have tried and failed 2 laxative/bowel therapies – polyethylene glycol + lactulose. For the treatment of OIC in adults with chronic non-cancer pain, member must have tried and failed Movantik.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 4 months, subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– *sildenafil 20mg tab*

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

Products Affected

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

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

Products Affected

– ROZEREM 8MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For approval, a prior use of zolpidem is required OR patient has had history of scheduled drug dependence.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of ROS1 rearragement or NTRK gene fusion mutation required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

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

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

Products Affected

– RYDAPT 25MG CAP (New Starts Only)

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

Products Affected

- SABRIL 500MG ORAL SOLN (New Starts Only)
- *vigabatrin 500mg tab (New Starts Only)*
- *vigadrone 500mg oral soln (New Starts Only)*
- SABRIL 500MG TAB (New Starts Only)
- *vigabatrin 50mg/ml oral soln (New Starts Only)*

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Prescribed for the treatment of an adult patient with Cushing disease AND Pituitary surgery is not an option OR Pituitary surgery was not curative.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Rheumatoid Arthritis (RA): Intolerance to or failure of therapy with Humira AND Enbrel. For Ankylosing Spondylitis (AS): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Cosentyx. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Ulcerative Colitis: Intolerance to or failure of thearpy with Humira.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Ulcerative Colitis : Prescribed by, or in consultation with a Gastroenterology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SIRTURO 100MG TAB

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

Products Affected

- SIVEXTRO 200MG INJ
- SIVEXTRO 200MG TAB

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

Products Affected

– SKYRIZI SYRINGE 150MG DOSE PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR soriatane.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– *diclofenac sodium 3% gel*

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

Products Affected

– SOLOSEC 2GM GRANULE PACKET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance to, or failure of therapy with 2 of the following 3 agents: metronidazole, clindamycin or tinidazole.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

- SPRITAM 1000MG ODT (New Starts Only)
- SPRITAM 500MG ODT (New Starts Only)
- SPRITAM 250MG ODT (New Starts Only)
- SPRITAM 750MG ODT (New Starts Only)

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

Products Affected

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

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

Products Affected

- STIVARGA 40MG TAB (New Starts Only)

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

Products Affected

– SUCRAID 8500UNIT/ML ORAL SOLN

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

Products Affected

- SUTENT 12.5MG CAP (New Starts Only)
- SUTENT 25MG CAP (New Starts Only)
- SUTENT 37.5MG CAP (New Starts Only)
- SUTENT 50MG CAP (New Starts Only)

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

Products Affected

- SYLATRON 200MCG INJ (New Starts Only)
- SYLATRON 300MCG INJ (New Starts Only)
- SYLATRON 600MCG INJ (New Starts Only)

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

Products Affected

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

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

Products Affected

- SYMPROIC 0.2MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Initial Therapy: Member must meet all criteria. 1) Opioid-induced constipation. 2) Trial and failure of polyethylene glycol (Miralax/Glycolax).
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– *trientine 250mg tab*

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

– *bexarotene 75mg cap (New Starts Only)*

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

– TIBSOVO 250MG TAB (New Starts Only)

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

Products Affected

- TOBI PODHALER KIT 28MG PACK
- *tobramycin 60mg/ml inh soln*

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

Products Affected

- AMCINONIDE 0.1% CREAM
- APEXICON 0.05% CREAM
- *betamethasone valerate 0.12% foam*
- *clobetasol propionate 0.05% foam*
- *clobetasol propionate 0.05% shampoo*
- CLOCORTOLONE 0.1% CREAM
- CLODERM 0.1% CREAM
- *desonide 0.05% cream*
- *fluticasone propionate 0.05% lotion*
- AMCINONIDE 0.1% OINTMENT
- *beser 0.05% lotion*
- *clobetasol propionate 0.05% e foam*
- *clobetasol propionate 0.05% lotion*
- *clobetasol propionate 0.05% spray*
- *clodan 0.05% shampoo*
- DESONATE 0.05% GEL
- *desonide 0.05% lotion*
- PANDEL 0.1% CREAM

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

Products Affected

- MULPLETA 3MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Member has a platelet count from the prior two weeks that shows less than 50,000 platelets per microliter.
Coverage Duration	Approved for 1 month subject to formulary change and member eligibility.
Other Criteria	

Products Affected

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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed topiramate (TOPAMAX) AND Patient has a diagnosis of partial-onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome OR is using for prophylaxis of migraine headache.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TURALIO 200MG CAP (New Starts Only)

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

Products Affected

- TYKERB 250MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Tykerb is prescribed in combination with capecitabine (Xeloda) AND The patient has advanced or metastatic breast cancer with tumor over-expression of HER2 AND The patient has received prior therapy including an anthracycline and a taxane and trastumab. Tykerb is prescribed in combination with letrozole for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TYMLOS 2MG/ML PEN INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has had at least 1 fracture, OR member has BMD screening results of -2.5 or below, OR member has previously used and failed a bisphosphonate.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has active mild to moderate ulcerative colitis and has tried and failed or was intolerant to mesalamine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

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

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

Products Affected

– VALCHLOR 0.016% GEL (New Starts Only)

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

Products Affected

- LOKELMA 10GM PACKET
- VELTASSA 16.8GM POWDER FOR ORAL SUSP
- VELTASSA 8.4GM POWDER FOR ORAL SUSP
- LOKELMA 5GM PACKET
- VELTASSA 25.2GM POWDER FOR ORAL SUSP

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- VOSEVI 400-100-100MG TAB

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

Products Affected

– VOTRIENT 200MG TAB (New Starts Only)

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

Products Affected

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

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

Products Affected

- XATMEP 2.5MG/ML ORAL SOLN

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

Products Affected

- XGEVA 120MG/1.7ML INJ

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

Products Affected

– XIFAXAN 550MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Prior Authorization required for quantities greater than 2 tablets per day. For quantities of 3 tablets per day, a diagnosis of IBS-D is required.

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1. If for moderate to severe persistent asthma: There must be objective evidence of reversible airway obstruction AND the patient's lgE level must be between 30 IU/ml and 700 IU/ml (OR between 30 IU/mL and 1300 IU/mL for members aged 6 to 12 years) , AND the patient must have a positive skin test or RAST test for specific allergic sensitivity and one of the following: Inadequately controlled asthma despite medium dose of inhaled corticosteroids for at least 3 months in combination with a trial of long-acting inhaled beta-agonists OR a leukotriene modifier and systemic steroids OR high dose inhaled corticosteroids are required to maintain adequate asthma control OR intolerance or contradindication to the previously listed drugs. 2. If for chronic idiopathic urticaria, patient remains symptomatic despite H1 antihistamine treatment or has intolerance or contraindication to H1 antihistamine treatment.
Age Restrictions	If for moderate to severe persistent asthma, patient must be at least 6 years old. If for chronic idiopathic urticaria, patient must be at least 12 years old.
Prescriber Restriction	Prescribed by, or in consultation with an Allergy Specialist, Pulmonary Specialist, Dermatology Specialist or Immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XOSPATA 40MG TAB (New Starts Only)

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

Products Affected

- XPOVIO 100MG ONCE WEEKLY PACK (New Starts Only)
- XPOVIO 80MG ONCE WEEKLY PACK (New Starts Only)
- XPOVIO 60MG ONCE WEEKLY PACK (New Starts Only)
- XPOVIO 80MG TWICE WEEKLY PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of prior therapies required and include at least 4 therapies, including at least 2 proteasome inhibitors, 2 immunomodulatory agents and an anti-CD38 monoclonal antibody.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- XTANDI 40MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic castration-resistant prostate cancer (mCRPC), failure of or intolerance to abiraterone (Zytiga equivalent) required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XULTOPHY 100UNIT-3.6MG/ML PEN INJ

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

Products Affected

– XYREM 500MG/ML ORAL SOLN

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

Products Affected

– *miglustat 100mg cap*

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

Products Affected

– ZEJULA 100MG CAP (New Starts Only)

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

Products Affected

– ZELBORAF 240MG TAB (New Starts Only)

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

Products Affected

– ZOLINZA 100MG CAP (New Starts Only)

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

Products Affected

– ZONTIVITY 2.08MG TAB

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	DIAGNOSIS A: Patient has relapsed CLL, defined as CLL progression less than 24 months since the completion of the last prior therapy AND idelalisib (ZYDELIG) will be used in combination with rituximab (RITUXAN). DIAGNOSIS B and C: Patient has relapsed follicular B-cell non-Hodgkin lymphoma (FL) OR Patient has relapsed small lymphocytic lymphoma (SLL) AND Patient has received at least two (2) prior systemic therapies.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ZYKADIA 150MG CAP (New Starts Only)
- ZYKADIA 150MG TAB (New Starts Only)

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

Products Affected

- *abiraterone 250mg tab (New Starts Only)*
- ZYTIGA 500MG TAB (New Starts Only)

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

Products Affected

- *linezolid 20mg/ml susp*
- *linezolid 600mg tab*
- *linezolid 2mg/ml inj*

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