# 2021 Prior Authorization Criteria

**abiraterone**

**Drugs**
*abiraterone*, ZYTIGA ORAL TABLET 500 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

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**Drugs**
*acitretin*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ACTEMRA ACTPEN, ACTEMRA SUBCUTANEOUS

**Exclusion Criteria**
N/A

**Required Medical Information**
For diagnosis of giant cell arteritis, juvenile arthritis, or rheumatoid arthritis when there has been a trial and failure of adalimumab (Humira)

**Age Restriction**
N/A

**Prescriber Restriction**
Must be prescribed by an oncologist or rheumatologist

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ACTIMMUNE

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ADEMPAS

**Exclusion Criteria**
N/A

**Required Medical Information**
For pulmonary arterial hypertension (PAH) (WHO Group 1): PAH was confirmed by right heart catheterization. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. For new starts only (excluding recurrent/persistent CTEPH after PEA): 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
AFINITOR, AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 3 MG, 5 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
For breast cancer: 1) The disease is recurrent or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, and 2) The requested medication is prescribed in combination with exemestane, fulvestrant, or tamoxifen, and 3) The patient has received endocrine therapy within 1 year. For renal cell carcinoma: 1) The disease is relapsed, metastatic or unresectable, and 2) For disease that is of predominantly clear cell histology, disease has progressed on prior therapy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
AIMOVIG AUTOINJECTOR

**Exclusion Criteria**
N/A

**Required Medical Information**
1) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 2) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 3) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ALECENSA

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*alosetron*

**Exclusion Criteria**
N/A

**Required Medical Information**
1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) Chronic IBS symptoms lasting at least 6 months AND 3) Gastrointestinal tract abnormalities have been ruled out AND 4) Inadequate response to conventional therapy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG, PROLASTIN-C INTRAVENOUS RECON SOLN, ZEMAIRA

**Exclusion Criteria**
N/A

**Required Medical Information**
For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema, 2) pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry), and 3) pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV1) greater than or equal to 25 percent and less than or equal to 80 percent of predicted.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ALUNBRIG

**Exclusion Criteria**
N/A

**Required Medical Information**
Treatment of anaplastic lymphoma kinase-positive (as detected by an approved test) metastatic non-small cell lung cancer in adults.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
ANADROL-50

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
APOKYN

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ARCALYST

**Exclusion Criteria**
N/A

**Required Medical Information**
For prevention of gout flares in members initiating or continuing urate-lowering therapy (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance, or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in members initiating or continuing urate-lowering therapy (continuation): 1) member must have achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
*armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg*

**Exclusion Criteria**
N/A

**Required Medical Information**
1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is Shift Work Disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
FANAPT ORAL TABLET, FANAPT ORAL TABLETS,DOSE PACK

**Exclusion Criteria**
N/A

**Required Medical Information**
The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
AURYXIA

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
Coverage will be denied if request is for an indication excluded from Part D.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
BALVERSA

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
BANZEL

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
1 year of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
BENLYSTA SUBCUTANEOUS

**Exclusion Criteria**
Severe active lupus nephritis. Severe active central nervous system lupus.

**Required Medical Information**
For systemic lupus erythematosus (SLE): 1) Patient is currently receiving standard therapy (e.g., corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) for SLE OR 2) patient is not currently receiving standard therapy for SLE because patient tried and had an inadequate response or intolerance to standard therapy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
BERINERT INTRAVENOUS KIT

**Exclusion Criteria**
N/A

**Required Medical Information**
For hereditary angioedema (HAE): patient has hereditary angioedema with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

## betaseron

**Drugs**
BETASERON SUBCUTANEOUS KIT

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

## bexarotene

**Drugs**
*bexarotene*, TARGRETIN TOPICAL

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*bosentan oral tablet 125 mg, 62.5 mg*

**Exclusion Criteria**
N/A

**Required Medical Information**
For pulmonary arterial hypertension (PAH) (WHO Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
BOSULIF

**Exclusion Criteria**
N/A

**Required Medical Information**
For chronic myeloid leukemia (CML), chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL): Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: 1) Patient received a hematopoietic stem cell transplant, OR 2) Patient has accelerated or blast phase CML, OR 3) Patient has chronic phase CML and meets one of the following conditions: a) high or intermediate risk for disease progression, or b) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor, OR 4) Patient has newly diagnosed CML. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
BRAFTOVI ORAL CAPSULE 75 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
BRIVIACT ORAL

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
4 years of age or older (tablets and oral solution).

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*buprenorphine hcl sublingual*

**Exclusion Criteria**
N/A

**Required Medical Information**
1) The requested drug is being prescribed for the treatment of opioid dependence AND 2) The patient is pregnant or breastfeeding, and the requested drug is being prescribed for induction therapy and/or subsequent maintenance therapy for opioid dependence treatment OR 3) The requested drug is being prescribed for induction therapy for transition from opioid use to opioid dependence treatment OR 4) The requested drug is being prescribed for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
CABOMETYX

**Exclusion Criteria**
N/A

**Required Medical Information**
For renal cell carcinoma: The disease is relapsed, unresectable, or metastatic. For non-small cell lung cancer: The disease is rearranged during transfection (RET) positive. For treatment of patients with hepatocellular carcinoma who have been previously treated with sorafenib.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
*calcipotriene scalp*, *calcipotriene topical cream*, *calcipotriene topical ointment*, *calcipotriene-betamethasone topical suspension*, ENSTILAR, TACLONEX TOPICAL SUSPENSION

**Exclusion Criteria**
N/A

**Required Medical Information**
1) The requested drug is being prescribed for the treatment of psoriasis AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic topical steroid.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
CALQUENCE

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
CAPRELSA

**Exclusion Criteria**
N/A

**Required Medical Information**
For NSCLC: the requested medication is used for NSCLC with RET gene rearrangements.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
CARBAGLU

**Exclusion Criteria**
N/A

**Required Medical Information**
For N-acetylglutamate synthase (NAGS) deficiency: Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
CAYSTON

**Exclusion Criteria**
N/A

**Required Medical Information**
For treatment of respiratory symptoms in cystic fibrosis patients: 1) Pseudomonas aeruginosa is present in the patient's airway cultures OR 2) The patient has a history of pseudomonas aeruginosa infection or colonization in the airways.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
CERDELGA

**Exclusion Criteria**
N/A

**Required Medical Information**
Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. The patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*clobazam*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
2 years of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*clomipramine*

**Exclusion Criteria**
N/A

**Required Medical Information**
1) The requested drug is being prescribed for one of the following: the treatment of Obsessive-Compulsive Disorder (OCD) or Panic Disorder AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI), mirtazapine OR 3) The requested drug is being prescribed for the treatment of Depression AND 4) The patient has experienced an inadequate treatment response, intolerance, or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI) , mirtazapine, bupropion

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*clorazepate dipotassium*

**Exclusion Criteria**
N/A

**Required Medical Information**
1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic relief in acute alcohol withdrawal OR 4) For the short-term relief of the symptoms of anxiety AND 5) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

## clozapine odt

**Drugs**
*clozapine oral tablet,disintegrating 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
COMETRIQ

**Exclusion Criteria**
N/A

**Required Medical Information**
For NSCLC: The requested medication is used for NSCLC with RET gene rearrangements.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
COPIKTRA, PIQRAY

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
COTELLIC

**Exclusion Criteria**
N/A

**Required Medical Information**
For melanoma (including brain metastases): 1) The disease is unresectable or metastatic, 2) The disease is positive for the BRAF V600E or V600K mutation, AND 3) The requested medication will be used in combination with vemurafenib.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
CYSTAGON

**Exclusion Criteria**
N/A

**Required Medical Information**
For nephropathic cystinosis: Diagnosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
CYSTARAN

**Exclusion Criteria**
N/A

**Required Medical Information**
For treatment of corneal cystine crystal accumulation in patients with cystinosis: 1) Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing, and 2) The patient has corneal cystine crystal accumulation.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*dalfampridine*

**Exclusion Criteria**
N/A

**Required Medical Information**
For multiple sclerosis new starts: Prior to initiating therapy, patient demonstrates sustained walking impairment. For multiple sclerosis continuation of therapy: Patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting the requested medication.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
DAURISMO

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*deferasirox oral tablet*, JADENU, JADENU SPRINKLE

**Exclusion Criteria**
N/A

**Required Medical Information**
For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
DEMSER

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*desvenlafaxine succinate*

**Exclusion Criteria**
N/A

**Required Medical Information**
Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following: a generic serotonin and norepinephrine reuptake inhibitor (SNRI), a generic selective serotonin reuptake inhibitor (SSRI), mirtazapine, bupropion

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*diazepam oral concentrate*, *diazepam oral solution 5 mg/5 ml (1 mg/ml)*, *diazepam oral tablet*, VALTOCO

**Exclusion Criteria**
N/A

**Required Medical Information**
1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For symptomatic relief in acute alcohol withdrawal OR 3) For use as an adjunct for the relief of skeletal muscle spasms OR 4) For adjunctive therapy in the treatment of convulsive disorders OR 5) For the short-term relief of the symptoms of anxiety AND 6) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
EMGALITY PEN, EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML

**Exclusion Criteria**
N/A

**Required Medical Information**
1) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 2) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 3) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
EMSAM

**Exclusion Criteria**
N/A

**Required Medical Information**
1) Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following antidepressants: bupropion, trazodone, mirtazapine, serotonin norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), tricyclic or tetracyclic antidepressants OR 2) Patient is unable to swallow oral formulations.

**Age Restriction**
18 years of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ENBREL MINI, ENBREL SUBCUTANEOUS RECON SOLN, ENBREL SUBCUTANEOUS SOLUTION, ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML), ENBREL SURECLICK

**Exclusion Criteria**
N/A

**Required Medical Information**
For diagnosis of psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis, plaque psoriasis, or juvenile arthritis when there has been a trial and failure of adalimumab (Humira)

**Age Restriction**
N/A

**Prescriber Restriction**
Must be prescribed by a dermatologist or rheumatologist

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ENDARI

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
5 years of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
EPCLUSA

**Exclusion Criteria**
N/A

**Required Medical Information**
For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
EPIDIOLEX

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ERIVEDGE

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ERLEADA

**Exclusion Criteria**
N/A

**Required Medical Information**
The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ESBRIET

**Exclusion Criteria**
N/A

**Required Medical Information**
For idiopathic pulmonary fibrosis (Initial Review Only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
FARYDAK

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
AJOVY AUTOINJECTOR, AYVAKIT, BRUKINSA, COSENTYX (2 SYRINGES), ENSPRYNG, *everolimus (antineoplastic) oral tablet 2.5 mg, 5 mg, 7.5 mg*, FINTEPLA, INREBIC, KOSELUGO, KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG, NAYZILAM, NUBEQA, PEMAZYRE, QINLOCK, RETEVMO, ROZLYTREK, TABRECTA, TALTZ SYRINGE, TAZVERIK, TUKYSA, TURALIO, XCOPRI, XCOPRI MAINTENANCE PACK, XCOPRI TITRATION PACK, XPOVIO, ZOLOFT ORAL CONCENTRATE

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

## fentanyl patch

**Drugs**
*fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr*

**Exclusion Criteria**
N/A

**Required Medical Information**
1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK, FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
Patient experienced an inadequate treatment response, intolerance, or contraindication to two generic alternatives from the following drug classes: selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs).

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*icatibant*

**Exclusion Criteria**
N/A

**Required Medical Information**
The requested drug is being used for the treatment of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER a) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR b) Patient has a family history of angioedema or the angioedema was refractory to a trial of antihistamine for at least one month.

**Age Restriction**
18 years of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
FORTEO, *teriparatide*

**Exclusion Criteria**
N/A

**Required Medical Information**
For postmenopausal osteoporosis: patient has ONE of the following (1. or 2.): 1) A history of fragility fractures, OR 2) A pre-treatment T-score of less than or equal to -2.5 or osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability and patient has ANY of the following: a) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) Patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy (e.g., injectable bisphosphonate or antiresorptive agent) OR c) Member has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has one of the following: 1) a history of osteoporotic vertebral or hip fracture, OR 2) a pre-treatment T-score of less than or equal to -2.5, OR 3) osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: 1) patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND 2) Patient has one of the following: a) a history of fragility fracture, OR b) a pre-treatment T-score of less than or equal to -2.5, OR c) osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment FRAX fracture probability.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
FYCOMPA ORAL SUSPENSION, FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
Partial-onset seizures: 4 years of age or older, PRIMARY generalized tonic-clonic seizures: 12 years of age or older.

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
GATTEX 30-VIAL

**Exclusion Criteria**
N/A

**Required Medical Information**
For short bowel syndrome (SBS) initial therapy: Patient was dependent on parenteral support for at least 12 months. For SBS continuation: Requirement for parenteral support has decreased from baseline while on therapy with the requested medication.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
GILENYA ORAL CAPSULE 0.5 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
GILOTRIF

**Exclusion Criteria**
N/A

**Required Medical Information**
For non-small cell lung cancer (NSCLC): Patient meets either of the following: A) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, or B) Patient has a known sensitizing EGFR mutation. For brain metastases from NSCLC, patient has a known sensitizing EGFR mutation.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
*glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*, GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
GRALISE 30-DAY STARTER PACK, GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 600 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
GENOTROPIN, GENOTROPIN MINIQUICK

**Exclusion Criteria**
Pediatric patients with closed epiphyses (except in patients with PWS).

**Required Medical Information**
Pediatric GHD: 1) Younger than 2.5 yrs old, when applicable: a) Pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2) 2.5 yrs old or older: a) Pre-tx 1-year ht velocity more than 2 SD below mean OR b) Pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean. Pediatric GHD: 1) Failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR 2) Pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) Patient is a neonate or was diagnosed with GHD as a neonate. TS: 1) Confirmed by karyotyping AND 2) Pre-treatment height is less than the 5th percentile for age. SGA: 1) Birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) Did not manifest catch-up growth by age 2. Adult GHD: 1) Failed 2 stimulation tests (peak below 5 ng/mL) or test with Macrilen (peak below 2.8 ng/ml) prior to starting tx, OR 2) Structural abnormality of the hypothalamus/pituitary AND 3 or more pituitary hormone deficiencies, OR 3) Childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS, OR 4) Low pre-tx IGF-1 and failed 1 stimulation test prior to starting tx.

**Age Restriction**
SGA: 2 years of age or older

**Prescriber Restriction**
Endocrinologist, pediatric endocrinologist, pediatric nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, geneticist.

**Coverage Duration**
1 year

**Other Criteria**
Renewal for pediatric GHD, TS, SGA, and adult GHD: patient is experiencing improvement.

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT, 3,000 UNIT

**Exclusion Criteria**
N/A

**Required Medical Information**
For hereditary angioedema (HAE): The requested drug is being used for the prevention of acute angioedema attacks. Patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has HAE with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, either 1) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
HARVONI ORAL TABLET 90-400 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
HETLIOZ

**Exclusion Criteria**
N/A

**Required Medical Information**
For Non-24-Hour Sleep-Wake Disorder: 1) for initial therapy and continuation of therapy: a) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and b) unable to perceive light in both eyes, AND 2) if currently on therapy with the requested drug, patient must meet at least one of the following: a) increased total nighttime sleep or b) decreased daytime nap duration.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*cyproheptadine*, DIGITEK ORAL TABLET 250 MCG (0.25 MG), DIGOX ORAL TABLET 250 MCG (0.25 MG), *digoxin oral solution 50 mcg/ml (0.05 mg/ml)*, *digoxin oral tablet 250 mcg (0.25 mg)*, *scopolamine base*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*phenobarbital*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*promethazine oral*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Rhinitis: 1) The patient has tried one of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to one of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The requested drug is being prescribed for urticaria AND 5) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 6) The drug is being requested for antiemetic therapy in postoperative patients or motion sickness AND 7) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 8) The requested drug is being prescribed for any of the following: allergic conjunctivitis, dermatographism, allergic reaction to blood or plasma, sedation, adjunct therapy with analgesics for postoperative pain, angioedema, or adjunct therapy with epinephrine for anaphylaxis after acute symptoms are controlled AND 9) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*cyclobenzaprine oral tablet 10 mg, 5 mg*, *methocarbamol oral*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
HUMIRA PEDIATRIC CROHNS START, HUMIRA PEN, HUMIRA PEN CROHNS-UC-HS START, HUMIRA PEN PSOR-UVEITS-ADOL HS, HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML, HUMIRA(CF) PEDI CROHNS STARTER, HUMIRA(CF) PEN CROHNS-UC-HS, HUMIRA(CF) PEN PSOR-UV-ADOL HS, HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML

**Exclusion Criteria**
N/A

**Required Medical Information**
For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD (e.g., tofacitinib). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to MTX OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy. For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates), OR 2) Intolerance or contraindication to conventional therapy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

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**Drugs**
IBRANCE

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ICLUSIG

**Exclusion Criteria**
N/A

**Required Medical Information**
For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
IDHIFA

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*imatinib oral tablet 100 mg, 400 mg*

**Exclusion Criteria**
N/A

**Required Medical Information**
For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For melanoma, c-Kit mutation is positive.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
IMBRUVICA

**Exclusion Criteria**
N/A

**Required Medical Information**
For mantle cell lymphoma: 1) the requested drug will be used in a patient who has received at least one prior therapy, OR 2) the requested drug will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen. For gastric MALT lymphoma and non-gastric MALT lymphoma: 1) disease is recurrent, refractory, or progressive, AND 2) the requested drug will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary central nervous system lymphoma: the disease is relapsed or refractory disease. For nodal marginal zone lymphoma or splenic marginal zone lymphoma: 1) disease is refractory or progressive, AND 2) the requested drug will be used as second-line or subsequent therapy. For histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma: the requested drug will be used in patients who have received prior chemoimmunotherapy. For diffuse large B-cell lymphoma: 1) disease is progressive or refractory AND 2) the requested drug will be used as second-line or subsequent therapy. For AIDS-related B-cell lymphoma: the requested drug will be used as second-line or subsequent therapy for relapsed disease. For post-transplant lymphoproliferative disorders: 1) the disease is partially responsive, persistent, or progressive AND 2) the requested drug will be used in patients who have received prior chemoimmunotherapy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
INCRELEX

**Exclusion Criteria**
N/A

**Required Medical Information**
For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone gene deletion in patients who have developed neutralizing antibodies to growth hormone, must meet all of the following prior to beginning therapy with the requested drug (new starts only): 1) height 3 or more standard deviations below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
For renewal, patient is experiencing improvement.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
INLYTA ORAL TABLET 1 MG, 5 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
For renal cell carcinoma, the disease is relapsed, metastatic, or unresectable.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*hydrocodone bitartrate*, HYSINGLA ER, *methadone oral solution*, *methadone oral tablet*, NUCYNTA ER

**Exclusion Criteria**
N/A

**Required Medical Information**
1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 5) The request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has severe continuous pain and the patient has received an immediate-release opioid for at least one week

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
IRESSA

**Exclusion Criteria**
N/A

**Required Medical Information**
For non-small cell lung cancer (NSCLC) (including brain metastases from NSCLC), patient has a known sensitizing EGFR mutation.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

## isotretinoin

**Drugs**
AMNESTEEM, CLARAVIS, *isotretinoin*, MYORISAN, ZENATANE

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*itraconazole oral capsule*

**Exclusion Criteria**
N/A

**Required Medical Information**
If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed by a fungal diagnostic test.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
GAMMAGARD S-D (IGA < 1 MCG/ML)

**Exclusion Criteria**
N/A

**Required Medical Information**
For CLL: 1) serum IgG less than 500 mg/dL OR 2) a history of recurrent bacterial infections. For BMT/HSCT: 1) IVIG is requested within the first 100 days post-transplant OR 2) serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL, OR 2) History of recurrent bacterial infections. For dermatomyositis and polymyositis: 1) at least one standard first-line treatment (corticosteroids or immunosuppressants) has been tried but was unsuccessful or not tolerated OR 2) patient is unable to receive standard therapy because of a contraindication or other clinical reason. For PRCA: PRCA is secondary to parvovirus B19 infection. For management of immune checkpoint inhibitor-related nervous system adverse events: 1) Patient has experienced a moderate or severe adverse event to a PD-1 or PD-L1 inhibitor, 2) IVIG is requested to manage one or more of the following nervous system adverse event types: pneumonitis, myasthenia gravis, peripheral neuropathy, encephalitis or transverse myelitis, and 3) the offending medication is temporarily being held or has been discontinued.

**Age Restriction**
For pediatric HIV infection: age 12 years or younger.

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
JAKAFI

**Exclusion Criteria**
N/A

**Required Medical Information**
For polycythemia vera: patients with inadequate response or intolerance to interferon therapy or hydroxyurea.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
JUXTAPID

**Exclusion Criteria**
N/A

**Required Medical Information**
For initiation of therapy to treat homozygous familial hypercholesterolemia: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), AND 2) Prior to initiation of treatment with the requested drug, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin, fibrate, bile acid sequestrant, ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the Food and Drug Administration (FDA) (maximally tolerated statin therapy may mean zero tolerance for those patients who cannot tolerate a statin), AND 3) Prior to initiation of treatment with the requested drug, patient is/was experiencing an inadequate response to such combination regimen as demonstrated by treated low-density lipoprotein cholesterol (LDL-C) greater than 100 mg/dL (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). For renewal of therapy to treat HoFH: 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, apolipoprotein B (ApoB), proprotein convertase subtilisin/kexin type 9 (PCSK9), or LDL receptor adaptor protein/ARH gene locus, OR 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, or b) Diagnosis of familial hypercholesterolemia (FH) by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature atherosclerotic cardiovascular disease (ASCVD) [before 55 years in men and 60 years in women], tendon xanthoma, or sudden premature cardiac death. Diagnosis of FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, or 2) Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or family history of myocardial infarction in a first degree relative before the age 60 or in a second degree relative before age 50, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 points.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
KALYDECO

**Exclusion Criteria**
N/A

**Required Medical Information**
For cystic fibrosis: The patient has one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation.

**Age Restriction**
6 months of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
The requested drug will not be used in combination with lumacaftor/ivacaftor or tezacaftor/ivacaftor.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*ketoconazole oral*

**Exclusion Criteria**
Acute or chronic liver disease. Current use with dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, alprazolam or simvastatin.

**Required Medical Information**
1) Patient has one of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis, OR 2) The requested drug is being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or surgery has not been curative.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
KISQALI, KISQALI FEMARA CO-PACK

**Exclusion Criteria**
N/A

**Required Medical Information**
For breast cancer: The requested drug is used in combination with an aromatase inhibitor, fulvestrant, or tamoxifen.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
KORLYM

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
KUVAN

**Exclusion Criteria**
N/A

**Required Medical Information**
For phenylketonuria: For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment, including before dietary management, phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced a reduction in blood phenylalanine level of greater than or equal to 30 percent from baseline OR the patient has demonstrated an improvement in neuropsychiatric symptoms.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
LENVIMA

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
LETAIRIS

**Exclusion Criteria**
N/A

**Required Medical Information**
Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

## lidocaine patches

**Drugs**
*lidocaine topical adhesive patch,medicated 5 %*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

## lonsurf

**Drugs**
LONSURF

**Exclusion Criteria**
N/A

**Required Medical Information**
For colorectal cancer: The disease is unresectable advanced or metastatic. Patient has progressed on treatment with EITHER a) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR b) irinotecan- AND oxaliplatin-based regimens.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
LORBRENA

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*leuprolide subcutaneous kit*, LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG, LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
For central precocious puberty (CPP), patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP confirmed by: a) a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay AND b) Assessment of bone age versus chronological age, and 2) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. For uterine fibroids, patient must meet one of the following: 1) Diagnosis of anemia (eg, hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) the requested medication will be used prior to surgery for uterine fibroids.

**Age Restriction**
CPP: Patient must be less than 12 years old if female and less than 13 years old if male.

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
LYNPARZA ORAL TABLET

**Exclusion Criteria**
N/A

**Required Medical Information**
For HER2-negative, recurrent or metastatic breast cancer, patient must have a deleterious or suspected deleterious germline BRCA mutation.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
MAVYRET

**Exclusion Criteria**
Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C).

**Required Medical Information**
For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*megestrol oral suspension 625 mg/5 ml (125 mg/ml)*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
MEKINIST

**Exclusion Criteria**
N/A

**Required Medical Information**
For brain metastasis from melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with dabrafenib. For adjuvant treatment of melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with dabrafenib. For unresectable or metastatic melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used as a single agent or in combination with dabrafenib. For non-small cell lung cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used in combination with dabrafenib. For anaplastic thyroid cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used in combination with dabrafenib. For uveal melanoma, the requested drug will be used as a single agent.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
MEKTOVI

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*memantine oral capsule,sprinkle,er 24hr*, *memantine oral solution*, *memantine oral tablet*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
This edit only applies to patients less than 30 years of age.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*miglustat*

**Exclusion Criteria**
N/A

**Required Medical Information**
For Gaucher disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*modafinil oral tablet 100 mg, 200 mg*

**Exclusion Criteria**
N/A

**Required Medical Information**
1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is shift work disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
NATPARA

**Exclusion Criteria**
Acute postsurgical hypoparathyroidism (within 6 months of surgery) and expected recovery from the hypoparathyroidism.

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
NERLYNX

**Exclusion Criteria**
N/A

**Required Medical Information**
For use as a single agent: the requested medication is initiated after completing adjuvant trastuzumab based therapy. For use in combination with capecitabine:  the requested medication is initiated in combination with capecitabine for the treatment of adult patients with advanced or metastatic HER2-positive breast cancer who have received two or more prior anti-HER2 based regimens in the metastatic setting.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
NEXAVAR

**Exclusion Criteria**
N/A

**Required Medical Information**
For thyroid carcinoma: histology is follicular, papillary, Hurthle cell or medullary. For acute myeloid leukemia: 1) the disease is relapsed or refractory, and 2) the patient has FLT3-ITD mutation-positive disease.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
NINLARO

**Exclusion Criteria**
N/A

**Required Medical Information**
For multiple myeloma: The requested drug will be used in combination with lenalidomide and dexamethasone OR pomalidomide and dexamethasone OR dexamethasone.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
NITYR

**Exclusion Criteria**
N/A

**Required Medical Information**
For hereditary tyrosinemia type 1: Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis).

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
Prior to initial therapy for neurogenic orthostatic hypotension (NOH), patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing. For continuation of therapy for NOH, patient must experience a sustained decrease in dizziness. For both initial and continuation of therapy for NOH, the requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) Primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) Dopamine beta hydroxylase deficiency, OR 3) Non-diabetic autonomic neuropathy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
NUCALA

**Exclusion Criteria**
N/A

**Required Medical Information**
For initial therapy for severe asthma with an eosinophilic phenotype: 1) Patient has baseline blood eosinophil count of at least 150 cells per microliter, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications at optimized doses: a) inhaled corticosteroid and b) additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline). For continuation therapy for severe asthma with an eosinophilic phenotype: Asthma control has improved on treatment with the requested drug, demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For initial therapy for eosinophilic granulomatosis with polyangiitis (EGPA): Patient has a history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level greater than 10 percent. For continuation of therapy for EGPA: Patient has a beneficial response to treatment with the requested drug, demonstrated by any of the following: 1) a reduction in the frequency of relapses, 2) a reduction in the daily oral corticosteroid dose, or 3) no active vasculitis.

**Age Restriction**
6 years of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
NUEDEXTA

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
NUPLAZID ORAL CAPSULE, NUPLAZID ORAL TABLET 10 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
The diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*octreotide acetate injection solution*

**Exclusion Criteria**
N/A

**Required Medical Information**
For acromegaly (initial): 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For meningiomas: patient has unresectable disease.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
For acromegaly (continuation of therapy): patient's IGF-1 level has decreased or normalized since initiation of therapy.

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
ODOMZO

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
OFEV

**Exclusion Criteria**
N/A

**Required Medical Information**
For idiopathic pulmonary fibrosis (Initial Review Only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
OLUMIANT ORAL TABLET 1 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD).

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
OPSUMIT

**Exclusion Criteria**
N/A

**Required Medical Information**
Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*fentanyl citrate buccal lozenge on a handle*

**Exclusion Criteria**
N/A

**Required Medical Information**
1) The requested drug is indicated for the treatment of breakthrough CANCER-related pain only. The requested drug is being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain. [Note: Ensure that the patient is opioid tolerant. Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 60 mg oral hydrocodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg oral oxymorphone per day, or an equianalgesic dose of another opioid medication daily for a week or longer.] AND 2) The International Classification of Diseases (ICD) diagnosis code provided supports the CANCER-RELATED diagnosis. [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER-RELATED diagnosis.]

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ORENCIA CLICKJECT, ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML

**Exclusion Criteria**
N/A

**Required Medical Information**
For diagnosis of psoriatic arthritis, rheumatoid arthritis or juvenile arthritis when there has been a trial and failure of adalimumab (Humira)

**Age Restriction**
N/A

**Prescriber Restriction**
Must be prescribed by a dermatologist or rheumatologist

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*nitisinone*, ORFADIN

**Exclusion Criteria**
N/A

**Required Medical Information**
For hereditary tyrosinemia type 1: Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis).

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ORKAMBI

**Exclusion Criteria**
N/A

**Required Medical Information**
For cystic fibrosis: the patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene.

**Age Restriction**
2 years of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
The requested drug will not be used in combination with ivacaftor or tezacaftor/ivacaftor.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*oxandrolone*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
Coverage will be denied if request is for an indication excluded from Part D.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
PEGASYS, PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML, SYLATRON

**Exclusion Criteria**
N/A

**Required Medical Information**
For chronic hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*sodium phenylbutyrate*

**Exclusion Criteria**
N/A

**Required Medical Information**
For urea cycle disorder: Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
For multiple myeloma: The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent AND a proteasome inhibitor. For Kaposi's sarcoma: Treatment of AIDS-related Kaposi's sarcoma in adults after failure of highly active antiretroviral therapy (HAART), treatment of Kaposi's sarcoma in HIV-negative adults.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
PRALUENT PEN

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
PROMACTA ORAL POWDER IN PACKET, PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to prior therapy such as corticosteroids or immunoglobulins, AND b) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) For continuation of therapy, platelet (plt) count response to the requested drug: a) Current plt count is less than or equal to 200,000/mcL OR b) Current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): For continuation of therapy following the initial 6 month approval for severe aplastic anemia: The patient must meet one of the following: 1) Current plt count is 50,000-200,000/mcL OR 2) Current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and patient is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL)

**Indications**
All FDA-approved Indications.

**Off Label Uses**

Formulary ID: 21436
Version Number: 7
Last Updated: 10/05/2020

**Drugs**
*quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 300 mg, 400 mg, 50 mg*

**Exclusion Criteria**
N/A

**Required Medical Information**
For schizophrenia, acute treatment of manic or mixed episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex, the acute treatment of depressive episodes associated with bipolar disorder, maintenance treatment of bipolar I disorder, as an adjunct to lithium or divalproex, adjunctive treatment of major depressive disorder, or maintenance monotherapy treatment in bipolar I disorder: The patient has had an inadequate treatment response, intolerance or contraindication to one of the following: aripiprazole, lurasidone, olanzapine, paliperidone, quetiapine immediate-release, risperidone, or ziprasidone

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*quinine sulfate*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
REGRANEX

**Exclusion Criteria**
N/A

**Required Medical Information**
For the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
RELISTOR SUBCUTANEOUS SOLUTION, RELISTOR SUBCUTANEOUS SYRINGE

**Exclusion Criteria**
N/A

**Required Medical Information**
1) The requested drug is being prescribed for opioid-induced constipation in an adult patient with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care OR 2) The requested drug is being prescribed for opioid-induced constipation in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has been tried. (Note: Examples are Amitiza or Movantik) AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain. (Note: Examples are Amitiza or Movantik) OR 6) The patient has a contraindication to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (Note: Examples are Amitiza or Movantik).

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
REVLIMID

**Exclusion Criteria**
N/A

**Required Medical Information**
For myelodysplastic syndrome (MDS): Low- to intermediate-1 risk MDS with symptomatic anemia

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
RUBRACA

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
RYDAPT

**Exclusion Criteria**
N/A

**Required Medical Information**
For acute myeloid leukemia (AML), AML must be FLT3 mutation-positive.

**Age Restriction**
18 years of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
SIGNIFOR

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*sildenafil (pulm.hypertension) oral tablet*

**Exclusion Criteria**
N/A

**Required Medical Information**
For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
SIRTURO

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
The requested drug is not being prescribed for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis, or infection caused by the non-tuberculous mycobacteria

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 120 MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3 ML

**Exclusion Criteria**
N/A

**Required Medical Information**
For acromegaly (initial): 1) patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
SOMAVERT

**Exclusion Criteria**
N/A

**Required Medical Information**
For acromegaly (initial): 1) patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
SPRYCEL

**Exclusion Criteria**
N/A

**Required Medical Information**
For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) For chronic phase CML, patient has one of the following a) patient is 21 years of age or younger, or b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib, or regorafenib.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
STELARA SUBCUTANEOUS SYRINGE

**Exclusion Criteria**
N/A

**Required Medical Information**
For diagnosis of psoriatic arthritis and plaque psoriasis when there has been a trial and failure of adalimumab (Humira) and etanercept (Enbrel). For diagnosis of Crohn's disease when there has been a trial and failure of adalimumab (Humira)

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
STIVARGA

**Exclusion Criteria**
N/A

**Required Medical Information**
For colorectal cancer: The disease is unresectable, advanced, or metastatic. The patient has progressed on treatment with EITHER 1) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR 2) irinotecan- AND oxaliplatin-based regimens.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
SUTENT

**Exclusion Criteria**
N/A

**Required Medical Information**
For renal cell carcinoma: Either 1) The disease is relapsed, metastatic, or unresectable, OR 2) The patient is at high risk of disease recurrence following nephrectomy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
SYMDEKO

**Exclusion Criteria**
N/A

**Required Medical Information**
For cystic fibrosis (CF): The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene OR the patient has a mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation

**Age Restriction**
6 years of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
Symdeko will not be used in combination with Orkambi or Kalydeco.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
SYMPAZAN

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
2 years of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
SYNRIBO

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
TAFINLAR

**Exclusion Criteria**
N/A

**Required Medical Information**
For brain metastases from melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with trametinib. For adjuvant treatment of melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with trametinib. For unresectable or metastatic melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used as a single agent or in combination with trametinib. For non-small cell lung cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used as a single agent or in combination with trametinib. For thyroid carcinoma, the tumor is positive for BRAF activating mutation with papillary, follicular, or Hurthle histology.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
TAGRISSO

**Exclusion Criteria**
N/A

**Required Medical Information**
For metastatic or recurrent non-small cell lung cancer (NSCLC), patient must have sensitizing EGFR mutation-positive NSCLC (including brain metastases from non-small cell lung cancer).

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
TALZENNA

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*erlotinib oral tablet 100 mg, 150 mg, 25 mg*, TARCEVA ORAL TABLET 100 MG, 150 MG, 25 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
For NSCLC (including brain metastases from NSCLC), patient has a known sensitizing EGFR mutation. For pancreatic cancer, the disease is locally advanced, unresectable, or metastatic.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
TASIGNA

**Exclusion Criteria**
N/A

**Required Medical Information**
For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) For chronic phase CML, the patient has one of the following: a) patient is 18 years of age or younger, b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
*tazarotene*, TAZORAC TOPICAL CREAM 0.05 %

**Exclusion Criteria**
N/A

**Required Medical Information**
For plaque psoriasis, the requested drug is being prescribed to treat less than 20 percent of the patient's body surface area.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*tetrabenazine oral tablet 12.5 mg, 25 mg*

**Exclusion Criteria**
N/A

**Required Medical Information**
For treatment of chorea associated with Huntington's disease and tardive dyskinesia: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine therapy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
For cachexia: Cachexia must be due to cancer or human immunodeficiency virus (HIV) infection. For Kaposi's sarcoma: The patient has human immunodeficiency virus (HIV) infection.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
TIBSOVO

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*tobramycin in 0.225 % nacl*

**Exclusion Criteria**
N/A

**Required Medical Information**
For cystic fibrosis and non-cystic fibrosis bronchiectasis, the patient must meet one of the following: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) the patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

## topical lidocaine

**Drugs**
*lidocaine hcl mucous membrane jelly*, *lidocaine hcl mucous membrane solution 4 % (40 mg/ml)*, *lidocaine topical ointment*, *lidocaine-prilocaine topical cream*

**Exclusion Criteria**
N/A

**Required Medical Information**
1) The requested drug is being used for topical anesthesia, 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are FDA-approved for topical use

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ANDRODERM, *testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)*, *testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)*

**Exclusion Criteria**
N/A

**Required Medical Information**
1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 3) Requested drug is being prescribed for gender dysphoria in a transgender male patient who is able to make an informed, mature decision to engage in therapy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

## topical tretinoin

**Drugs**
AVITA, *tretinoin topical cream*, *tretinoin topical gel 0.01 %, 0.025 %*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 11.25 MG, 3.75 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
CLOVIQUE, *trientine*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
TRIKAFTA

**Exclusion Criteria**
N/A

**Required Medical Information**
Trikafta: For cystic fibrosis (CF): The patient has at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation.

**Age Restriction**
12 years of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
Trikafta will not be used in combination with Symdeko, Orkambi or Kalydeco.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
Patient experienced an inadequate treatment response, intolerance, or contraindication to two generic alternatives from the following drug classes: selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs).

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
TYKERB

**Exclusion Criteria**
N/A

**Required Medical Information**
For HER2-positive breast cancer, the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
TYMLOS

**Exclusion Criteria**
N/A

**Required Medical Information**
For postmenopausal osteoporosis: patient has ONE of the following: 1) a history of fragility fractures, OR 2) a pre-treatment T-score of less than or equal to -2.5 or osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
Patient has high Fracture Risk Assessment Tool (FRAX) fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
VALCHLOR

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
VENCLEXTA, VENCLEXTA STARTING PACK

**Exclusion Criteria**
N/A

**Required Medical Information**
For AML, patient meets any of the following: 1) the patient is 60 years of age or older, OR 2) the requested drug will be used as a component of repeating the initial successful induction regimen if late relapse, OR 3) the patient has comorbidities that preclude use of intensive induction chemotherapy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
VERSACLOZ

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
VERZENIO

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*vigabatrin*, VIGADRONE

**Exclusion Criteria**
N/A

**Required Medical Information**
For complex partial seizures (CPS): patient had an inadequate response to at least 2 alternative therapies for CPS.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
VIIBRYD ORAL TABLET, VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)

**Exclusion Criteria**
N/A

**Required Medical Information**
Patient experienced an inadequate treatment response, intolerance, or contraindication to two generic alternatives from the following drug classes: selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs).

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
VITRAKVI

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
VIZIMPRO

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
*voriconazole intravenous*, *voriconazole oral suspension for reconstitution*

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
The patient will be using the requested drug orally or intravenously.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
VOSEVI

**Exclusion Criteria**
Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)

**Required Medical Information**
For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
VOTRIENT

**Exclusion Criteria**
N/A

**Required Medical Information**
For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma, AND 2) The patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, or e) extremity/superficial trunk, head/neck sarcoma.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG, VRAYLAR ORAL CAPSULE,DOSE PACK

**Exclusion Criteria**
N/A

**Required Medical Information**
The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
XALKORI

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
XELJANZ ORAL TABLET 10 MG, 5 MG, XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR 11 MG, 22 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For active psoriatic arthritis (new starts only): Patient meets BOTH of the following criteria: 1) Inadequate response to MTX or other nonbiologic DMARDs OR a prior biologic DMARD, AND 2) The requested drug is used in combination with a nonbiologic DMARD. For moderately to severely active ulcerative colitis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to at least one conventional therapy option (e.g., aminosalicylates), or 2) Inadequate response or intolerance to a prior biologic DMARD.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
XGEVA

**Exclusion Criteria**
N/A

**Required Medical Information**
For hypercalcemia of malignancy, condition is refractory to intravenous (IV) bisphosphonate therapy or there is a clinical reason to avoid IV bisphosphonate therapy.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
XIFAXAN ORAL TABLET 550 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
1) The requested drug is being prescribed to reduce the risk of overt hepatic encephalopathy (HE) recurrence OR 2) The patient has the diagnosis of irritable bowel syndrome with diarrhea (IBS-D) AND 3) If the patient has previously received treatment with the requested drug, the patient has experienced a recurrence of symptoms AND 4) The patient has not already received an initial 14-day course of treatment and two additional 14-day courses of treatment with the requested drug OR 5) The patient has not previously received treatment with the requested drug

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
XOLAIR

**Exclusion Criteria**
N/A

**Required Medical Information**
For allergic asthma initial therapy: 1) Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, and 3) Patient has inadequate asthma control despite current treatment with both of the following medications at optimized doses: a) Inhaled corticosteroid, and b) Additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For allergic asthma continuation therapy only: Patient's asthma control has improved on treatment with the requested drug since initiation of therapy. For chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), and 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks. For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy.

**Age Restriction**
For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older.

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
XOSPATA

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
18 years of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
XTANDI

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
XYREM

**Exclusion Criteria**
N/A

**Required Medical Information**
1) The requested drug is being prescribed for the treatment of excessive daytime sleepiness in a patient 7 years of age or older with narcolepsy and 2) If the patient is 18 years of age or older, the patient experienced an inadequate treatment response, intolerance, or contraindication to at least one central nervous system (CNS) wakefulness promoting drug and at least one central nervous system (CNS) stimulant drug OR 3) If the patient is less than 18 years of age, the patient experienced an inadequate treatment response, intolerance, or contraindication to at least one central nervous system (CNS) stimulant drug (NOTE: Examples of a central nervous system (CNS) stimulant drug are amphetamine, dextroamphetamine, or methylphenidate. Example of a central nervous system (CNS) wakefulness promoting drug is armodafinil. Coverage of armodafinil or amphetamines may require prior authorization). OR 4) The requested drug is being prescribed for the treatment of cataplexy in a patient 7 years of age or older with narcolepsy

**Age Restriction**
7 years of age or older

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ZARXIO

**Exclusion Criteria**
Use of the requested product within 24 hours prior to or following chemotherapy or radiotherapy.

**Required Medical Information**
For prophylaxis or treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ZEJULA

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
For the maintenance treatment of adult patients with advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to first-line platinum-based chemotherapy, and the treatment of adult patients with advanced ovarian, fallopian tube, or primary peritoneal cancer who have been treated with three or more prior chemotherapy regimens and whose cancer is associated with homologous recombination deficiency (HRD) positive status. Treatment is being started or was started no later than 8 weeks after the most recent platinum-based chemotherapy.

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ZELBORAF

**Exclusion Criteria**
N/A

**Required Medical Information**
For brain metastases with melanoma, all of the following criteria must be met: 1) The tumor is positive for BRAF V600 activating mutation (e.g., BRAF V600E or V600K mutation), and 2) The requested drug will be used in combination with cobimetinib. For non-small cell lung cancer, tumor is positive for the BRAF V600E mutation. For thyroid carcinoma, tumor is positive for BRAF mutation. For rectal cancer, tumor is positive for the BRAF V600E mutation. For colon cancer, tumor is positive for the BRAF V600E mutation.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ZOLINZA

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ZYDELIG

**Exclusion Criteria**
N/A

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

**Drugs**
ZYKADIA

**Exclusion Criteria**
N/A

**Required Medical Information**
For NSCLC, patient has recurrent or metastatic ALK-positive or ROS1-positive disease. For inflammatory myofibroblastic tumor, the tumor is ALK-positive. For brain metastases, patient has ALK-positive NSCLC.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All Medically-accepted Indications.

**Off Label Uses**

**Drugs**
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG

**Exclusion Criteria**
N/A

**Required Medical Information**
Tolerability with oral olanzapine has been established.

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
1 year

**Other Criteria**
N/A

**Indications**
All FDA-approved Indications.

**Off Label Uses**

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