2024 PRIOR AUTHORIZATION CRITERIA

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Prior Authorization Group Description:
Acthar Gel PA
Drug Name(s)
Acthar
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of infantile spasm OR
    b. Patient has a diagnosis of nephrotic syndrome AND ONE of the following:
        i. Patient has failed a conventional agent (i.e., prednisone, tacrolimus) for the requested indication OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to a conventional agent OR
    c. Patient has a diagnosis of multiple sclerosis AND ALL of the following:
        i. Patient is experiencing an acute exacerbation AND
        ii. If indicated, there is evidence of a claim that the patient is currently being treated with a disease modifying drug (DMD) within the past 90 days [e.g., Avonex, dimethyl fumarate, glatiramer] to control disease progression OR has an intolerance, FDA labeled contraindication, or hypersensitivity to a DMD AND
        iii. ONE of the following:
            1. Patient has failed corticosteroid therapy (e.g., methylprednisolone) within the last 30 days OR
            2. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to corticosteroid therapy OR

Criteria continues: see Other Criteria
Age Restriction:
For diagnosis of infantile spasm, patient is less than 2 years of age.
Prescriber Restrictions:
Coverage Duration:
6 months for infantile spasm, 1 month for all other indications
Other Criteria:
    d. Patient has a diagnosis of rheumatic disorder (e.g., ankylosing spondylitis, juvenile idiopathic arthritis, juvenile rheumatoid arthritis, psoriatic arthritis, rheumatoid arthritis) AND ALL of the following:
        i. The requested agent will be used as adjunct therapy for short-term administration (to tide the patient over an acute episode or exacerbation) AND

ii. There is evidence of a claim that the patient is currently being treated with a conventional agent within the past 90 days [e.g., DMARD (methotrexate, leflunomide), biologics (Humira)] to control disease progression AND

iii. ONE of the following:

1. Patient has failed corticosteroid therapy (e.g., methylprednisolone) within the last 30 days

OR

2. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to corticosteroid therapy OR

e. Patient has a diagnosis of systemic lupus erythematosus (SLE) disease AND the patient will continue standard SLE therapy [corticosteroids (e.g., methylprednisolone, prednisone), hydroxychloroquine, immunosuppressives (e.g., azathioprine, methotrexate, oral cyclophosphamide)] in combination with the requested agent OR

f. Patient has another FDA approved indication AND ONE of the following:

i. Patient has failed corticosteroid therapy (e.g., methylprednisolone) within the last 30 days OR

ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to corticosteroid therapy OR

g. Patient has another indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:

i. Patient has failed corticosteroid therapy (e.g., methylprednisolone) within the last 30 days OR

ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to corticosteroid therapy AND

2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Prior Authorization Group Description:
Actimmune PA
Drug Name(s)
Actimmune
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Acyclovir Topical PA
Drug Name(s)
Acyclovir
Zovirax
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Adakveo PA
Drug Name(s)
Adakveo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of sickle cell disease AND
2. Patient is using the requested agent to reduce the frequency of vasoocclusive crises of sickle cell disease AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to maximally tolerated dose of hydroxyurea OR
    B. Patient has an intolerance or hypersensitivity to hydroxyurea OR
    C. Patient has an FDA labeled contraindication to hydroxyurea AND
4. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of sickle cell disease AND
3. Patient is using the requested agent to reduce the frequency of vasoocclusive crises of sickle cell disease AND
4. Patient has had clinical benefit with the requested agent AND
5. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Adbry PA
Drug Name(s)
Adbry
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of moderate-to-severe atopic dermatitis AND BOTH of the following:
    A. ONE of the following:
        i. Patient has tried and failed a topical steroid (e.g., triamcinolone) OR
        ii. Patient has an intolerance or hypersensitivity to a topical steroid OR
        iii. Patient has an FDA labeled contraindication to a topical steroid AND
    B. ONE of the following:
        i. Patient has tried and failed a topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus) OR
        ii. Patient has an intolerance or hypersensitivity to a topical calcineurin inhibitor OR
        iii. Patient has an FDA labeled contraindication to a topical calcineurin inhibitor AND
2. Patient will NOT be using the requested agent in combination with another biologic agent or a JAK inhibitor for the requested indication (e.g., Cibinqo, Opzelura, Dupixent, Rinvoq) AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of moderate-to-severe atopic dermatitis AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another biologic agent or a JAK inhibitor for the requested indication (e.g., Cibinqo, Opzelura, Dupixent, Rinvoq) AND
5. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, dermatologist, immunologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Adlyxin PA
Drug Name(s)
Adlyxin
Adlyxin Starter Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of type 2 diabetes mellitus AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. BOTH of the following:
        i. ONE of the following:
            1. Patient's medication history includes use of an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) within the past 90 days OR
            2. Patient had an ineffective treatment response to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            3. Patient has an intolerance or hypersensitivity to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            4. Patient has an FDA labeled contraindication to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Aimovig PA
Drug Name(s)
Aimovig
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of migraine AND
2. The requested agent is being used for migraine prophylaxis AND
3. Patient has 4 migraine headaches or more per month AND
4. ONE of the following:
    A. Patient has tried and had an inadequate response to a conventional migraine prophylaxis agent [e.g., beta blockers (propranolol), anticonvulsants (divalproex, topiramate)] OR
    B. Patient has an intolerance, or hypersensitivity to a conventional migraine prophylaxis agent OR
    C. Patient has an FDA labeled contraindication to a conventional migraine prophylaxis agent AND
5. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of migraine AND
3. The requested agent is being used for migraine prophylaxis AND
4. Patient has had clinical benefit with the requested agent AND
5. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Ajovy PA
Drug Name(s)
Ajovy
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of migraine AND
2. The requested agent is being used for migraine prophylaxis AND
3. Patient has 4 migraine headaches or more per month AND
4. ONE of the following:
    A. Patient has tried and had an inadequate response to a conventional migraine prophylaxis agent [e.g., beta blockers (propranolol), anticonvulsants (divalproex, topiramate)] OR
    B. Patient has an intolerance, or hypersensitivity to a conventional migraine prophylaxis agent OR
    C. Patient has an FDA labeled contraindication to a conventional migraine prophylaxis agent AND
5. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of migraine AND
3. The requested agent is being used for migraine prophylaxis AND
4. Patient has had clinical benefit with the requested agent AND
5. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Alosetron PA
Drug Name(s)
Alosetron Hydrochloride
Lotronex
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of irritable bowel syndrome with severe diarrhea (IBS-D) AND
2. Patient's sex is female AND
3. Patient exhibits at least ONE of the following:
    a. Frequent and severe abdominal pain/discomfort OR
    b. Frequent bowel urgency or fecal incontinence OR
    c. Disability or restriction of daily activities due to IBS AND
4. Prescriber has ruled out anatomic or biochemical abnormalities of the gastrointestinal tract
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Alpha-1-Proteinase Inhibitor PA - Aralast/Prolastin-C/Zemaira
Drug Name(s)
Aralast Np
Prolastin-C
Zemaira
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of alpha-1 antitrypsin deficiency (AATD) with clinically evident emphysema AND
2. Patient has a pre-treatment serum alpha-1 antitrypsin (AAT) level less than 11 micromol/L (80 mg/dL by immunodiffusion or 57 mg/dL using nephelometry) AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of alpha-1 antitrypsin deficiency (AATD) with clinically evident emphysema AND
3. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Alpha-1-Proteinase Inhibitor PA – Glassia
Drug Name(s)
Glassia
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of alpha-1 antitrypsin deficiency (AATD) with clinically evident emphysema AND
2. Patient has a pre-treatment serum alpha-1 antitrypsin (AAT) level less than 11 micromol/L (80 mg/dL by immunodiffusion or 57 mg/dL using nephelometry) AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of alpha-1 antitrypsin deficiency (AATD) with clinically evident emphysema AND
3. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Amantadine ER PA – Gocovri
Drug Name(s)
Gocovri
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of Parkinson's disease AND
2. ONE of the following:
    A. The requested agent will be used for the treatment of dyskinesia OR
    B. The requested agent will be used for the adjunctive treatment in patients experiencing "off" episodes AND
3. The requested agent will be used in combination with levodopa-based therapy
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Amantadine ER PA - Osmolex ER
Drug Name(s)
Osmolex Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of Parkinson's disease OR
    B. BOTH of the following:
        i. Patient has a diagnosis of drug-induced extrapyramidal reaction AND
        ii. Prescriber has assessed and adjusted, if applicable, any medications known to cause extrapyramidal symptoms
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Anabolic Steroid PA – Danazol
Drug Name(s)
Danazol
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has ONE of the following diagnoses:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR
    B. Prescriber has provided information in support of therapy with more than one agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Androgen Injectable PA – Aveed
Drug Name(s)
Aveed
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient's sex is male with a diagnosis of primary or secondary (hypogonadotropic) hypogonadism AND
2. ONE of the following:
    A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels:
        i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR
        ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR
    B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels:
        i. Total serum testosterone level that is within OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR
        ii. Free serum testosterone level is within OR below the testing laboratory's normal range AND
3. ONE of the following:
    A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR
    B. Prescriber has provided information in support of therapy with more than one agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Androgen Injectable PA - testosterone cypionate
Drug Name(s)
Depo-Testosterone
Testosterone Cypionate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    A. Patient's sex is male with AIDS/HIV-associated wasting syndrome AND BOTH of the following:
        i. ONE of the following:
            a. Unexplained involuntary weight loss (greater than 10% baseline body weight within 12 months, or 7.5% within 6 months) OR
            b. Body mass index less than 20 kg/m2 OR
            c. At least 5% total body cell mass (BCM) loss within 6 months OR
            d. BCM less than 35% of total body weight and BMI less than 27 kg/m2 AND
        ii. All other causes of weight loss have been ruled out OR
    B. Patient's sex is female with metastatic/inoperable breast cancer OR
    C. Patient's sex is male with primary or secondary (hypogonadotropic) hypogonadism OR
    D. Patient's sex is male and is an adolescent with delayed puberty AND
2. If the patient's sex is a male, ONE of the following:
    A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels:
        i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR
        ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR
    B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels:
        i. Total serum testosterone level that is within OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR
        ii. Free serum testosterone level is within OR below the testing laboratory's normal range AND
3. ONE of the following:
    A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR
    B. Prescriber has provided information in support of therapy with more than one agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

Approval will be 6 months for delayed puberty, 12 months for all other indications
Other Criteria:

Prior Authorization Group Description:
Androgen Injectable PA - testosterone enanthate
Drug Name(s)
Testosterone Enanthate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    A. Patient's sex is male with AIDS/HIV-associated wasting syndrome AND BOTH of the following:
        i. ONE of the following:
            a. Unexplained involuntary weight loss (greater than 10% baseline body weight within 12 months, or 7.5% within 6 months) OR
            b. Body mass index less than 20 kg/m2 OR
            c. At least 5% total body cell mass (BCM) loss within 6 months OR
            d. BCM less than 35% of total body weight and BMI less than 27 kg/m2 AND
        ii. All other causes of weight loss have been ruled out OR
    B. Patient's sex is female with metastatic/inoperable breast cancer OR
    C. Patient's sex is male with primary or secondary (hypogonadotropic) hypogonadism OR
    D. Patient's sex is male and is an adolescent with delayed puberty AND
2. If the patient's sex is a male, ONE of the following:
    A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels:
        i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR
        ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR
    B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels:
        i. Total serum testosterone level that is within OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR
        ii. Free serum testosterone level is within OR below the testing laboratory's normal range AND
3. ONE of the following:
    A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR
    B. Prescriber has provided information in support of therapy with more than one agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 months for delayed puberty, 12 months for all other indications

Other Criteria:

Prior Authorization Group Description:
Androgen Injectable PA – Xyosted
Drug Name(s)
Xyosted
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    A. Patient's sex is male with AIDS/HIV-associated wasting syndrome AND BOTH of the following:
        i. ONE of the following:
            a. Unexplained involuntary weight loss (greater than 10% baseline body weight within 12 months, or 7.5% within 6 months) OR
            b. Body mass index less than 20 kg/m2 OR
            c. At least 5% total body cell mass (BCM) loss within 6 months OR
            d. BCM less than 35% of total body weight and BMI less than 27 kg/m2 AND
        ii. All other causes of weight loss have been ruled out OR
    B. Patient's sex is male with primary or secondary (hypogonadotropic) hypogonadism AND
2. Patient's sex is male with ONE of the following:
    A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels:
        i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR
        ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR
    B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels:
        i. Total serum testosterone level that is within OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR
        ii. Free serum testosterone level is within OR below the testing laboratory's normal range AND
3. ONE of the following:
    A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR
    B. Prescriber has provided information in support of therapy with more than one agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Androgen Oral PA
Drug Name(s)
Methitest
Methyltestosterone
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    A. Patient's sex is male with cryptorchidism OR
    B. Patient's sex is male with hypogonadism OR
    C. Patient's sex is male and is an adolescent with delayed puberty OR
    D. Patient's sex is female with metastatic/inoperable breast cancer AND
2. If the patient's sex is male, ONE of the following:
    A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels:
        i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR
        ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR
    B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels:
        i. Total serum testosterone level that is within OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR
        ii. Free serum testosterone level is within OR below the testing laboratory's normal range AND
3. ONE of the following:
    A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR
    B. Prescriber has provided information in support of therapy with more than one agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 months for delayed puberty, 12 months for all other indications
Other Criteria:

Prior Authorization Group Description:
Androgen Topical PA
Drug Name(s)
Androgel
Androgel Pump
Fortesta
Natesto
Testim
Testosterone
Testosterone Pump
Testosterone Topical Solution
Vogelxo
Vogelxo Pump
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    A. Patient has AIDS/HIV-associated wasting syndrome AND BOTH of the following:
        i. ONE of the following:
            a. Unexplained involuntary weight loss (greater than 10% baseline body weight within 12 months, or 7.5% within 6 months) OR
            b. Body mass index less than 20 kg/m2 OR
            c. At least 5% total body cell mass (BCM) loss within 6 months OR
            d. In men: BCM less than 35% of total body weight and BMI less than 27 kg/m2 OR
            e. In women: BCM less than 23% of total body weight and BMI less than 27 kg/m2 AND
        ii. All other causes of weight loss have been ruled out OR
    B. Patient's sex is male with primary or secondary (hypogonadotropic) hypogonadism AND
2. If the patient's sex is male, ONE of the following:
    A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels:
        i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR
        ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR
    B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels:

i. Total serum testosterone level that is within OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR

ii. Free serum testosterone level is within OR below the testing laboratory's normal range AND

3. ONE of the following:

A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR

B. Prescriber has submitted information in support of therapy with more than one agent

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Antipsychotics PA
Drug Name(s)
Abilify
Abilify Mycite Maintenance Kit
Abilify Mycite Starter Kit
Aripiprazole
Aripiprazole Odt
Asenapine Maleate Sl
Chlorpromazine Hydrochloride
Clozapine
Clozapine Odt
Clozaril
Fanapt
Fanapt Titration Pack
Fluphenazine Decanoate
Fluphenazine Hydrochloride
Geodon
Haldol Decanoate 100
Haldol Decanoate 50
Haloperidol
Haloperidol Decanoate
Haloperidol Lactate
Invega
Latuda
Loxapine
Lurasidone
Lybalvi
Molindone Hydrochloride
Olanzapine
Olanzapine Odt
Olanzapine/Fluoxetine
Paliperidone Er
Perphenazine
Pimozide
Quetiapine Fumarate
Quetiapine Fumarate Er
Rexulti
Risperdal
Risperidone
Risperidone Odt
Saphris
Secuado
Seroquel

Seroquel Xr
Symbyax
Thioridazine Hcl
Thiothixene
Trifluoperazine Hcl
Versacloz
Ziprasidone Mesylate
Zyprexa
Zyprexa Relprevv
Zyprexa Zydis

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age.

Criteria for approval require BOTH of the following:

1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Approval authorizations will apply to the requested medication only.

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Apomorphine Inj PA
Drug Name(s)
Apokyn
Apomorphine Hydrochloride
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. The requested agent will be used to treat acute, intermittent hypomobility, “off” episodes (“end of dose wearing off” and unpredictable “on/off” episodes) associated with advanced Parkinson’s disease AND
2. The requested agent will be used in combination with agents used for therapy in Parkinson’s disease (e.g., levodopa, dopamine agonist, monoamine oxidase B inhibitor) AND
3. Patient will NOT be using the requested agent in combination with a 5-HT3 antagonist (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron)
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient’s diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient’s diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Aptensio XR PA
Drug Name(s)
Aptensio Xr
Methylphenidate Hydrochloride Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Arcalyst PA
Drug Name(s)
Arcalyst
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has been diagnosed with Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Auto-inflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS) OR
    B. BOTH of the following:
        i. Patient has a diagnosis of deficiency of interleukin-1 receptor antagonist AND
        ii. The requested agent is being used for maintenance of remission OR
    C. BOTH of the following:
        i. Patient has a diagnosis of recurrent pericarditis AND
        ii. The requested agent is being used to reduce the risk of recurrence AND
2. Patient will NOT be using the requested agent in combination with another biologic agent
Age Restriction:
For diagnosis of CAPS including FCAS or MWS, patient is 12 years of age or over

For diagnosis of recurrent pericarditis and reduction in risk of recurrence, patient is 12 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Arikayce PA
Drug Name(s)
Arikayce
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Mycobacterium avium complex (MAC) lung disease AND
2. Patient has not achieved negative sputum cultures despite at least 6 consecutive months of treatment with standard combination antibiotic therapy for MAC lung disease [e.g., standard combination may include a macrolide (clarithromycin, azithromycin), a rifamycin (rifampin, rifabutin), and ethambutol] AND
3. Patient will continue treatment with a combination antibiotic therapy for MAC lung disease with the requested agent [e.g., combination may include a macrolide (clarithromycin, azithromycin), a rifamycin (rifampin, rifabutin), and ethambutol]

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Mycobacterium avium complex (MAC) lung disease AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will continue treatment with a combination antibiotic therapy for MAC lung disease with the requested agent [e.g., combination may include a macrolide (clarithromycin, azithromycin), a rifamycin (rifampin, rifabutin), and ethambutol]
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., infectious disease, immunologist, pulmonologist, thoracic specialist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Armodafinil PA
Drug Name(s)
Armodafinil
Nuvigil
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another target agent (i.e., modafinil)
Age Restriction:
Patient is 17 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Asceniv PA
Drug Name(s)
Asceniv
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ONE of the following:
1. Patient has ONE of the following diagnoses:
    A. Primary immunodeficiency [e.g., congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency] OR
    B. B-cell chronic lymphocytic leukemia OR multiple myeloma AND ONE of the following:
        i. Patient has a history of infections OR
        ii. Patient has evidence of specific antibody deficiency OR
        iii. Patient has hypogammaglobulinemia OR
    C. Idiopathic thrombocytopenia purpura AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone), or immunosuppressants (e.g., azathioprine)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    D. Dermatomyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone) or immunosuppressants (e.g., azathioprine)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    E. Polymyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone) or immunosuppressants (e.g., azathioprine)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    F. Severe rheumatoid arthritis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., tumor necrosis factor antagonists (e.g., Humira), DMARDS (e.g., methotrexate)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

Criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 6 months for indications in Other Criteria, 12 months for all others

Other Criteria:

G. Myasthenia gravis (MG) AND ONE of the following:

i. Patient is in acute myasthenic crisis OR

ii. Patient has severe refractory MG (e.g., major functional disability/weakness) AND ONE of the following:

a) Patient has failed ONE immunomodulator therapy (i.e., corticosteroid, pyridostigmine, or azathioprine) OR

b) Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE immunomodulator therapy OR

H. Multiple sclerosis (MS) AND BOTH of the following:

i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND

ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication to TWO MS agents (e.g., Avonex, Betaseron, Copaxone, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Mayzent, Plegridy, teriflunomide, Vumerity) OR

I. Acquired von Willebrand hemophilia AND ONE of the following:

i. Patient has failed ONE conventional therapy (e.g., desmopressin solution, von Willebrand factor replacement therapy, corticosteroids, cyclophosphamide, FEIBA, or recombinant factor VIIa) OR

ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

J. Refractory pemphigus vulgaris AND ONE of the following:

i. Patient has failed ONE conventional immunosuppressive therapy (e.g., azathioprine, cyclophosphamide, mycophenolate, corticosteroids) OR

ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional immunosuppressive therapy OR

2. ONE of the following:

A. Patient has another FDA labeled indication for the requested agent OR

B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Indications with 6 months approval duration: Acquired von Willebrand hemophilia, Guillain-Barre Syndrome, Lambert-Eaton myasthenia syndrome, Kawasaki disease, CMV induced pneumonitis in solid organ transplant, Toxic shock syndrome due to invasive group A streptococcus, Toxic epidermal necrolysis and Stevens-Johnson syndrome

Drug is also subject to Part B versus Part D review.

Prior Authorization Group Description:
Atopic Dermatitis PA – Eucrisa
Drug Name(s)
Eucrisa
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of atopic dermatitis AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to a topical corticosteroid or topical corticosteroid combination preparation (e.g., hydrocortisone, triamcinolone) OR
    B. Patient has an intolerance or hypersensitivity to a topical corticosteroid or topical corticosteroid combination preparation OR
    C. Patient has an FDA labeled contraindication to a topical corticosteroid or topical corticosteroid combination preparation
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Atopic Dermatitis PA – Pimecrolimus
Drug Name(s)
Elidel
Pimecrolimus
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ONE of the following:
1. Patient has a diagnosis of atopic dermatitis or vulvar lichen sclerosus AND ONE of the following:
    A. Patient has tried and had an inadequate response to a topical corticosteroid or topical corticosteroid combination preparation (e.g., hydrocortisone, triamcinolone) OR
    B. Patient has an intolerance or hypersensitivity to a topical corticosteroid or topical corticosteroid combination preparation OR
    C. Patient has an FDA labeled contraindication to a topical corticosteroid or topical corticosteroid combination preparation OR
2. Patient has a diagnosis of facial seborrheic dermatitis associated with HIV infection AND BOTH of the following:
    A. Patient is currently on an antiretroviral treatment regimen AND
    B. ONE of the following:
        i. Patient has tried and had an inadequate response to a topical corticosteroid or topical antifungal treatment (e.g., hydrocortisone, triamcinolone, ketoconazole) OR
        ii. Patient has an intolerance or hypersensitivity to a topical corticosteroid or topical antifungal treatment OR
        iii. Patient has an FDA labeled contraindication to a topical corticosteroid or topical antifungal treatment OR
3. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Atopic Dermatitis PA – Tacrolimus
Drug Name(s)
Tacrolimus
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ONE of the following:
1. Patient has a diagnosis of atopic dermatitis AND ONE of the following:
    A. Patient has tried and had an inadequate response to a topical corticosteroid or topical corticosteroid combination preparation (e.g., hydrocortisone, triamcinolone) OR
    B. Patient has an intolerance or hypersensitivity to a topical corticosteroid or topical corticosteroid combination preparation OR
    C. Patient has an FDA labeled contraindication to a topical corticosteroid or topical corticosteroid combination preparation OR
2. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Atovaquone PA
Drug Name(s)
Atovaquone
Mepron
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            1. Patient has a diagnosis of mild-to-moderate Pneumocystis jirovecii pneumonia OR
            2. Patient is using the requested agent for prevention of Pneumocystis jirovecii pneumonia AND
        ii. ONE of the following:
            1. Patient has an intolerance or hypersensitivity to trimethoprim/sulfamethoxazole (TMP/SMX) OR
            2. Patient has an FDA labeled contraindication to trimethoprim/sulfamethoxazole (TMP/SMX) OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Auryxia PA
Drug Name(s)
Auryxia
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used as iron replacement therapy to treat iron deficiency anemia AND FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has a diagnosis of hyperphosphatemia AND BOTH of the following:
    A. Patient has chronic kidney disease AND
    B. Patient is on dialysis
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Austedo PA
Drug Name(s)
Austedo
Austedo Xr
Austedo Xr Titration Kit
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of chorea associated with Huntington's disease AND BOTH of the following:
        i. ONE of the following:
            1. Patient does NOT have a current diagnosis of depression OR
            2. Patient has a current diagnosis of depression and is being treated for depression AND
        ii. ONE of the following:
            1. Patient does NOT have a diagnosis of passive suicidal ideation OR
            2. Patient has a diagnosis of passive suicidal ideation and must NOT be actively suicidal OR
    B. Patient has a diagnosis of tardive dyskinesia AND ONE of the following:
        i. Prescriber has reduced the dose of or discontinued any medications known to cause tardive dyskinesia (i.e., dopamine receptor blocking agents) OR
        ii. Prescriber has provided clinical rationale indicating that a reduced dose or discontinuation of any medications known to cause tardive dyskinesia is not appropriate AND
2. Patient will NOT be using the requested agent in combination with a monoamine oxidase inhibitor (MAOI) AND
3. Patient will NOT be using the requested agent in combination with reserpine
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Azstarys PA
Drug Name(s)
Azstarys
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Belsomra PA
Drug Name(s)
Belsomra
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benign Prostatic Hyperplasia PA – Tadalafil
Drug Name(s)
Cialis
Tadalafil 2.5Mg, 5Mg
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used to treat erectile dysfunction AND FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of benign prostatic hyperplasia (BPH) AND
2. ONE of the following:
    a. Patient has tried and had an inadequate response to two alpha blocker agents (e.g., terazosin, doxazosin, tamsulosin) OR
    b. Patient has an intolerance or hypersensitivity to two alpha blocker agents (e.g., terazosin, doxazosin, tamsulosin) OR
    c. Patient has an FDA labeled contraindication to two alpha blocker agents (e.g., terazosin, doxazosin, tamsulosin)

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benlysta IV PA
Drug Name(s)
Benlysta IV
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. ONE of the following:
    a. Patient has a diagnosis of active systemic lupus erythematosus (SLE) disease AND the following:
        i. Patient will continue standard SLE therapy [corticosteroids (e.g., methylprednisolone, prednisone), hydroxychloroquine, immunosuppressives (e.g., azathioprine, methotrexate, oral cyclophosphamide)] in combination with the requested agent OR
    b. Patient has a diagnosis of active lupus nephritis (LN) AND the following:
        i. Patient will continue standard LN therapy [corticosteroids (e.g., methylprednisolone, prednisone), immunosuppressives (e.g., azathioprine, mycophenolate)] in combination with the requested agent AND
2. Patient will NOT be using the requested agent in combination with another biologic agent AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    a. Patient has diagnosis of active systemic lupus erythematosus (SLE) disease AND the following:
        i. Patient will continue standard SLE therapy [corticosteroids (e.g., methylprednisolone, prednisone), hydroxychloroquine, immunosuppressives (e.g., azathioprine, methotrexate, oral cyclophosphamide)] in combination with the requested agent OR
    b. Patient has a diagnosis of active lupus nephritis (LN) AND the following:
        i. Patient will continue standard LN therapy [corticosteroids (e.g., methylprednisolone, prednisone), immunosuppressives (e.g., azathioprine, mycophenolate)] in combination with the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another biologic agent AND
5. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
For diagnosis of active systemic lupus erythematosus (SLE) disease, patient is 5 years of age or over. For diagnosis of active lupus nephritis (LN), patient is 5 years of age or over.
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Benlysta SC PA
Drug Name(s)
Benlysta SC
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. ONE of the following:
    a. Patient has a diagnosis of active systemic lupus erythematosus (SLE) disease AND the following:
        i. Patient will continue standard SLE therapy [corticosteroids (e.g., methylprednisolone, prednisone), hydroxychloroquine, immunosuppressives (e.g., azathioprine, methotrexate, oral cyclophosphamide)] in combination with the requested agent OR
    b. Patient has a diagnosis of active lupus nephritis (LN) AND the following:
        i. Patient will continue standard LN therapy [corticosteroids (e.g., methylprednisolone, prednisone), immunosuppressives (e.g., azathioprine, mycophenolate)] in combination with the requested agent AND
2. Patient will NOT be using the requested agent in combination with another biologic agent AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    a. Patient has diagnosis of active systemic lupus erythematosus (SLE) disease AND the following:
        i. Patient will continue standard SLE therapy [corticosteroids (e.g., methylprednisolone, prednisone), hydroxychloroquine, immunosuppressives (e.g., azathioprine, methotrexate, oral cyclophosphamide)] in combination with the requested agent OR
    b. Patient has a diagnosis of active lupus nephritis (LN) AND the following:
        i. Patient will continue standard LN therapy [corticosteroids (e.g., methylprednisolone, prednisone), immunosuppressives (e.g., azathioprine, mycophenolate)] in combination with the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another biologic agent AND
5. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
For diagnosis of active systemic lupus erythematosus (SLE) disease, patient is 18 years of age or over.
For diagnosis of active lupus nephritis (LN), patient is 18 years of age or over.
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA - Chlordiazepoxide
Drug Name(s)
Chlordiazepoxide Hydrochloride
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            a. Anxiety disorder AND ONE of the following:
                1) Patient has tried and had an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
                2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR
                3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR
            b. Alcohol withdrawal OR
            c. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Chlordiazepoxide /amitriptyline
Drug Name(s)
Chlordiazepoxide/Amitriptyline
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. ALL of the following:
        i. Patient has ONE of the following diagnoses:
            a. Moderate to severe depression with moderate to severe anxiety AND ONE of the following:
                1) Patient has tried and had an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
                2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR
                3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR
            b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. ONE of the following:
            a. Patient has not taken a monoamine oxidase inhibitor (MAOI) in the past 30 days OR
            b. Patient has taken an MAOI in the past 30 days AND will discontinue at least 14 days prior to starting the requested agent AND
        iii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Clobazam
Drug Name(s)
Clobazam
Onfi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            a. Seizure disorder OR
            b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Clorazepate
Drug Name(s)
Clorazepate Dipotassium
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            a. Seizure disorder OR
            b. Anxiety disorder AND ONE of the following:
                1) Patient has tried and has an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
                2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR
                3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR
            c. Alcohol withdrawal OR
            d. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Diazepam
Drug Name(s)
Diazepam
Diazepam Intensol
Valium
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            a. Seizure disorder OR
            b. Anxiety disorder AND ONE of the following:
                1) Patient has tried and had an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
                2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR
                3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR
            c. Skeletal muscle spasms OR
            d. Alcohol withdrawal OR
            e. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Estazolam
Drug Name(s)
Estazolam
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of insomnia OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Lorazepam
Drug Name(s)
Ativan
Lorazepam
Lorazepam Intensol
Loreev Xr
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            a. Anxiety disorder AND ONE of the following:
                1) Patient has tried and had an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
                2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR
                3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR
            b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Oxazepam
Drug Name(s)
Oxazepam
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            a. Anxiety disorder AND ONE of the following:
                1) Patient has tried and had an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
                2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR
                3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR
            b. Alcohol withdrawal OR
            c. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Sympazan
Drug Name(s)
Sympazan
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            a. Seizure disorder OR
            b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Bethkis PA
Drug Name(s)
Bethkis
Tobramycin (Bethkis)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. Documentation has been provided that indicates the patient has a Pseudomonas aeruginosa respiratory infection AND
3. ONE of the following:
    a. Patient is NOT currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam, inhaled tobramycin) OR
    b. Patient is currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam, inhaled tobramycin) AND ONE of the following:
        i. Prescriber has confirmed that the other inhaled antibiotic will be discontinued, and that therapy will be continued only with the requested agent OR
        ii. Prescriber has provided information in support of another inhaled antibiotic therapy used concurrently with or alternating with (i.e., continuous alternating therapy) the requested agent

Drug is also subject to Part B versus Part D review.
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Bexarotene Gel PA
Drug Name(s)
Bexarotene Gel
Targretin Gel
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of stage IA or IB cutaneous T-cell lymphoma (CTCL) with cutaneous lesions OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. ONE of the following:
            1. BOTH of the following:
                a. Patient has a diagnosis of stage IA or IB cutaneous T-cell lymphoma (CTCL) with cutaneous lesions AND
                b. ONE of the following:
                    i. Patient has refractory or persistent disease despite a previous treatment trial with a skin-directed therapy (e.g., topical corticosteroid, topical imiquimod) OR
                    ii. Patient has an intolerance or hypersensitivity to a previous treatment trial with a skin-directed therapy (e.g., topical corticosteroid, topical imiquimod) OR
                    iii. Patient has an FDA labeled contraindication to a previous treatment trial with a skin-directed therapy (e.g., topical corticosteroid, topical imiquimod) OR
            2. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist, oncologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND
        iii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 12 months

Other Criteria:

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of stage IA or IB cutaneous T-cell lymphoma (CTCL) with cutaneous lesions OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
3. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Patient has had clinical benefit with the requested agent AND
        ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist, oncologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND
        iii. Patient does NOT have any FDA labeled contraindications to the requested agent

Prior Authorization Group Description:
Biologic Immunomodulators PA – Actemra
Drug Name(s)
Actemra
Actemra Actpen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred agents (Cyltezo, Enbrel, Humira, Xeljanz tablets, or Xeljanz oral solution) is required for diagnosis of juvenile idiopathic arthritis

Use of TWO preferred agents (Cyltezo, Enbrel, Humira, Rinvoq, Xeljanz tablets, or Xeljanz XR) is required for diagnosis of rheumatoid arthritis

NO preferred agent is required for diagnoses of giant cell arteritis, systemic sclerosis-associated interstitial lung disease (SSc-ILD), or cytokine release syndrome

Prior Authorization Group Description:
Biologic Immunomodulators PA – Amjevita
Drug Name(s)
Amjevita
Amjevita Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of juvenile idiopathic arthritis

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Humira, Skyrizi, or Stelara) is required for diagnosis of adult Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cyltezo, Humira, or Stelara) is required for diagnosis of ulcerative colitis

Use of ONE preferred agent (Cyltezo or Humira) is required for diagnosis of pediatric Crohn's disease

NO preferred agent is required for diagnosis of adult fistulizing Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, or Humira) is required for diagnosis of hidradenitis suppurativa

Use of TWO preferred agents (Cyltezo and Humira) is required for diagnosis of uveitis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Avsola
Drug Name(s)
Avsola
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Humira, Skyrizi, or Stelara) is required for diagnosis of adult Crohn's disease

Use of TWO preferred agents (Cyltezo, Humira, or Stelara) is required for diagnosis of adult ulcerative colitis

Use of ONE preferred agent (Cyltezo or Humira) is required for diagnosis of pediatric Crohn's disease

Only the preferred agent Humira is required for diagnosis of pediatric ulcerative colitis

NO preferred agent is required for diagnosis of adult fistulizing Crohn's disease

Prior Authorization Group Description:
Biologic Immunomodulators PA – Cimzia
Drug Name(s)
Cimzia
Cimzia Starter Kit
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
        a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Humira, Skyrizi, or Stelara) is required for diagnosis of adult Crohn's disease

Only the preferred agent Cosentyx is required for diagnosis of non-radiographic axial spondyloarthritis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Cosentyx
Drug Name(s)
Cosentyx
Cosentyx Sensoready Pen
Cosentyx Uno Inj
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR
    D. Patient's diagnosis does NOT require a conventional prerequisite agent OR
    E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR
    F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR
    G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Use of ONE conventional prerequisite agent is required for diagnoses of psoriatic arthritis or plaque psoriasis

NO prerequisites are required for diagnoses of ankylosing spondylitis, enthesitis related arthritis, hidradenitis suppurativa, or non-radiographic axial spondyloarthritis

Formulary conventional agents for psoriatic arthritis include cyclosporine, leflunomide, methotrexate, or sulfasalazine

Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids

Prior Authorization Group Description:
Biologic Immunomodulators PA – Cyltezo
Drug Name(s)
Cyltezo
Cyltezo Pen
Cyltezo Pen-Cd/Uc/Hs Starter Pack
Cyltezo Pen-Ps Starter Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR
D. Patient's diagnosis does NOT require a conventional prerequisite agent OR
E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR
F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR
G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

Approval will be 12 weeks for initial use for ulcerative colitis, 12 months for all others

Other Criteria:

Use of ONE conventional prerequisite agent is required for diagnoses of psoriatic arthritis, plaque psoriasis, rheumatoid arthritis, juvenile idiopathic arthritis, Crohn's disease, or moderate ulcerative colitis

NO prerequisites are required for diagnoses of ankylosing spondylitis, hidradenitis suppurativa, severe ulcerative colitis, or uveitis

Formulary conventional agents for rheumatoid arthritis, juvenile idiopathic arthritis, or psoriatic arthritis include leflunomide, methotrexate, or sulfasalazine

Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids

Formulary conventional agents for Crohn's disease include methotrexate, sulfasalazine, corticosteroids, azathioprine, or mercaptopurine

Formulary conventional agents for moderate ulcerative colitis include 5-aminosalicylates, corticosteroids, azathioprine, or mercaptopurine

Prior Authorization Group Description:
Biologic Immunomodulators PA – Enbrel
Drug Name(s)
Enbrel
Enbrel Mini
Enbrel Sureclick
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR
    D. Patient's diagnosis does NOT require a conventional prerequisite agent OR
    E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR
    F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR
    G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Use of ONE conventional prerequisite agent is required for diagnoses of psoriatic arthritis, plaque psoriasis, rheumatoid arthritis, or juvenile idiopathic arthritis

NO prerequisites are required for a diagnosis of ankylosing spondylitis

Formulary conventional agents for rheumatoid arthritis, juvenile idiopathic arthritis, or psoriatic arthritis include leflunomide, methotrexate, or sulfasalazine

Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids

Prior Authorization Group Description:
Biologic Immunomodulators PA – Hadlima
Drug Name(s)
Hadlima
Hadlima Pushtouch Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of juvenile idiopathic arthritis

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Humira, Skyrizi, or Stelara) is required for diagnosis of adult Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cyltezo, Humira, or Stelara) is required for diagnosis of ulcerative colitis

Use of ONE preferred agent (Cyltezo or Humira) is required for diagnosis of pediatric Crohn's disease

NO preferred agent is required for diagnosis of adult fistulizing Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, or Humira) is required for diagnosis of hidradenitis suppurativa

Use of TWO preferred agents (Cyltezo and Humira) is required for diagnosis of uveitis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Hulio
Drug Name(s)
Adalimumab-Fkjp Kit
Adalimumab-Fkjp Pen Kit
Hulio Inj Kit
Hulio Pen Kit
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:

Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of juvenile idiopathic arthritis

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Humira, Skyrizi, or Stelara) is required for diagnosis of adult Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cyltezo, Humira, or Stelara) is required for diagnosis of ulcerative colitis

Use of ONE preferred agent (Cyltezo or Humira) is required for diagnosis of pediatric Crohn's disease

NO preferred agent is required for diagnosis of adult fistulizing Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, or Humira) is required for diagnosis of hidradenitis suppurativa

Use of TWO preferred agents (Cyltezo and Humira) is required for diagnosis of uveitis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Humira
Drug Name(s)
Humira
Humira Pediatric Crohns Disease Starter Pack
Humira Pen
Humira Pen-Cd/Uc/Hs Starter
Humira Pen-Pediatric Uc Starter Pack
Humira Pen-Ps/Uv Starter
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR
    D. Patient's diagnosis does NOT require a conventional prerequisite agent OR
    E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR
    F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR
    G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:

Prescriber Restrictions:
Coverage Duration:
Approval will be 12 weeks for initial use for ulcerative colitis, 12 months for all others
Other Criteria:
Use of ONE conventional prerequisite agent is required for diagnoses of psoriatic arthritis, plaque psoriasis, rheumatoid arthritis, juvenile idiopathic arthritis, Crohn's disease, or moderate ulcerative colitis

NO prerequisites are required for diagnoses of ankylosing spondylitis, hidradenitis suppurativa, severe ulcerative colitis, or uveitis

Formulary conventional agents for rheumatoid arthritis, juvenile idiopathic arthritis, or psoriatic arthritis include leflunomide, methotrexate, or sulfasalazine

Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids

Formulary conventional agents for Crohn's disease include methotrexate, sulfasalazine, corticosteroids, azathioprine, or mercaptopurine

Formulary conventional agents for moderate ulcerative colitis include 5-aminosalicylates, corticosteroids, azathioprine, or mercaptopurine

Prior Authorization Group Description:
Biologic Immunomodulators PA – Hyrimoz
Drug Name(s)
Adalimumab-Adaz
Adalimumab-Adaz Pen
Hyrimoz
Hyrimoz Pediatric Cd Starter Pack
Hyrimoz Pen
Hyrimoz Pen-Ps Starter Pack
Hyrimoz Pen-Uc Starter Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND

4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of juvenile idiopathic arthritis

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Humira, Skyrizi, or Stelara) is required for diagnosis of adult Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cyltezo, Humira, or Stelara) is required for diagnosis of ulcerative colitis

Use of ONE preferred agent (Cyltezo or Humira) is required for diagnosis of pediatric Crohn's disease

NO preferred agent is required for diagnosis of adult fistulizing Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, or Humira) is required for diagnosis of hidradenitis suppurativa

Use of TWO preferred agents (Cyltezo and Humira) is required for diagnosis of uveitis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Idacio
Drug Name(s)
Adalimumab-Aacf Pen Kit
Idacio
Idacio Pen
Idacio Pen - CD Starter Pack
Idacio Pen - PS Starter Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of juvenile idiopathic arthritis

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Humira, Skyrizi, or Stelara) is required for diagnosis of adult Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cyltezo, Humira, or Stelara) is required for diagnosis of ulcerative colitis

Use of ONE preferred agent (Cyltezo or Humira) is required for diagnosis of pediatric Crohn's disease

NO preferred agent is required for diagnosis of adult fistulizing Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, or Humira) is required for diagnosis of hidradenitis suppurativa

Use of TWO preferred agents (Cyltezo and Humira) is required for diagnosis of uveitis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Ilumya
Drug Name(s)
Ilumya
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
        a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Inflectra
Drug Name(s)
Inflectra
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Humira, Skyrizi, or Stelara) is required for diagnosis of adult Crohn's disease

Use of TWO preferred agents (Cyltezo, Humira, or Stelara) is required for diagnosis of adult ulcerative colitis

Use of ONE preferred agent (Cyltezo or Humira) is required for diagnosis of pediatric Crohn's disease

Only the preferred agent Humira is required for diagnosis of pediatric ulcerative colitis

NO preferred agent is required for diagnosis of adult fistulizing Crohn's disease

Prior Authorization Group Description:
Biologic Immunomodulators PA – Kevzara
Drug Name(s)
Kevzara
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Use of TWO preferred agents (Cyltezo, Enbrel, Humira, Rinvoq, Xeljanz tablets, or Xeljanz XR) is required for diagnosis of rheumatoid arthritis

NO preferred agent is required for diagnosis of polymyalgia rheumatica

Prior Authorization Group Description:
Biologic Immunomodulators PA – Kineret
Drug Name(s)
Kineret
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Use of TWO preferred agents (Cyltezo, Enbrel, Humira, Rinvoq, Xeljanz tablets, or Xeljanz XR) is required for diagnosis of rheumatoid arthritis

NO preferred agent is required for diagnoses of Neonatal-Onset Multisystem Inflammatory Disease (NOMID) or Deficiency of Interleukin-1 Receptor Antagonist (DIRA)

Prior Authorization Group Description:
Biologic Immunomodulators PA – Litfulo
Drug Name(s)
Litfulo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
NO preferred agent is required for diagnosis of alopecia areata

Prior Authorization Group Description:
Biologic Immunomodulators PA – Olumiant
Drug Name(s)
Olumiant
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Use of TWO preferred agents (Cyltezo, Enbrel, Humira, Rinvoq, Xeljanz tablets, or Xeljanz XR) is required for diagnosis of rheumatoid arthritis

NO preferred agent is required for diagnosis of alopecia areata

Prior Authorization Group Description:
Biologic Immunomodulators PA – Orencia
Drug Name(s)
Orencia
Orencia Clickject
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred agents (Cyltezo, Enbrel, Humira, Xeljanz tablets, or Xeljanz oral solution) is required for diagnosis of juvenile idiopathic arthritis

Use of TWO preferred agents (Cyltezo, Enbrel, Humira, Rinvoq, Xeljanz tablets, or Xeljanz XR) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Rinvoq, Skyrizi, Stelara, Tremfya, Xeljanz tablets, or Xeljanz XR) is required for diagnosis of psoriatic arthritis

NO preferred agent is required for diagnosis of prophylaxis of acute graft vs host disease

Prior Authorization Group Description:
Biologic Immunomodulators PA – Remicade
Drug Name(s)
Infliximab
Remicade
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Humira, Skyrizi, or Stelara) is required for diagnosis of adult Crohn's disease

Use of TWO preferred agents (Cyltezo, Humira, or Stelara) is required for diagnosis of adult ulcerative colitis

Use of ONE preferred agent (Cyltezo or Humira) is required for diagnosis of pediatric Crohn's disease

Only the preferred agent Humira is required for diagnosis of pediatric ulcerative colitis

NO preferred agent is required for diagnosis of adult fistulizing Crohn's disease

Prior Authorization Group Description:
Biologic Immunomodulators PA – Renflexis
Drug Name(s)
Renflexis
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Humira, Skyrizi, or Stelara) is required for diagnosis of adult Crohn's disease

Use of TWO preferred agents (Cyltezo, Humira, or Stelara) is required for diagnosis of adult ulcerative colitis

Use of ONE preferred agent (Cyltezo or Humira) is required for diagnosis of pediatric Crohn's disease

Only the preferred agent Humira is required for diagnosis of pediatric ulcerative colitis

NO preferred agent is required for diagnosis of adult fistulizing Crohn's disease

Prior Authorization Group Description:
Biologic Immunomodulators PA – Riabni
Drug Name(s)
Riabni
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ONE of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
2. ALL of the following:
    A. ONE of the following:
        i. Patient has a diagnosis of rheumatoid arthritis AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. Patient has another FDA labeled indication or an indication that is supported in CMS approved compendia AND
    B. Patient has been screened for hepatitis B infection measuring hepatitis B surface antigen (HBsAg) and hepatitis B core antibody (anti-HBc) and has begun therapy, if appropriate, prior to receiving the requested agent AND
    C. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND
    D. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. ONE of the following:

A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
B. Prescriber states the patient is currently being treated with the requested agent OR
C. ALL of the following:
    i. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
    ii. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
    iii. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND
    iv. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines

Use of TWO preferred agents (Cyltezo, Enbrel, Humira, Rinvoq, Xeljanz tablets, or Xeljanz XR) is required for diagnosis of rheumatoid arthritis

ALL other diagnoses do NOT require any preferred agents

Prior Authorization Group Description:
Biologic Immunomodulators PA – Rinvoq
Drug Name(s)
Rinvoq
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. BOTH of the following:
            a. Patient has an FDA labeled indication other than moderate to severe atopic dermatitis for the requested agent AND
            b. ONE of the following:
                1. Patient's medication history indicates use of preferred TNF agent(s) OR
                2. Patient has an intolerance or hypersensitivity to preferred TNF agent(s) OR
                3. Patient has an FDA labeled contraindication to preferred TNF agent(s) OR
                4. The request is for an FDA labeled indication that is not covered by preferred TNF agent(s) OR
        ii. Patient has a diagnosis of moderate to severe atopic dermatitis AND ONE of the following:
            1. Patient's medication history indicates use of TWO conventional prerequisite agents (i.e., ONE formulary topical corticosteroid AND ONE formulary topical calcineurin inhibitor) for the requested indication OR
            2. Patient has an intolerance or hypersensitivity to TWO conventional prerequisite agents (i.e., ONE formulary topical corticosteroid AND ONE formulary topical calcineurin inhibitor) for the requested indication OR
            3. Patient has an FDA labeled contraindication to TWO conventional prerequisite agents (i.e., ONE formulary topical corticosteroid AND ONE formulary topical calcineurin inhibitor) for the requested indication AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:

Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Use of ONE preferred TNF (Cyltezo, Enbrel, or Humira) is required for diagnoses of ankylosing spondylitis, rheumatoid arthritis, or psoriatic arthritis

Use of ONE preferred TNF (Cyltezo or Humira) is required for diagnoses of ulcerative colitis or Crohn's disease

Use of TWO conventional prerequisite agents (i.e., ONE formulary topical corticosteroid AND ONE formulary topical calcineurin inhibitor) are required for diagnosis of moderate to severe atopic dermatitis

NO preferred TNF agents are required for diagnosis of non-radiographic Axial Spondyloarthritis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Rituxan
Drug Name(s)
Rituxan
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ONE of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
2. ALL of the following:
    A. ONE of the following:
        i. Patient has a diagnosis of rheumatoid arthritis AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. Patient has another FDA labeled indication or an indication that is supported in CMS approved compendia AND
    B. Patient has been screened for hepatitis B infection measuring hepatitis B surface antigen (HBsAg) and hepatitis B core antibody (anti-HBc) and has begun therapy, if appropriate, prior to receiving the requested agent AND
    C. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND
    D. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. ONE of the following:

A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
B. Prescriber states the patient is currently being treated with the requested agent OR
C. ALL of the following:
    i. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
    ii. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
    iii. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND
    iv. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines

Use of TWO preferred agents (Cyltezo, Enbrel, Humira, Rinvoq, Xeljanz tablets, or Xeljanz XR) is required for diagnosis of rheumatoid arthritis

ALL other diagnoses do NOT require any preferred agents

Prior Authorization Group Description:
Biologic Immunomodulators PA - Rituxan Hycela
Drug Name(s)
Rituxan Hycela
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Patient has been screened for hepatitis B infection measuring hepatitis B surface antigen (HBsAg) and hepatitis B core antibody (anti-HBc) and has begun therapy, if appropriate, prior to receiving the requested agent AND
        ii. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND
        iii. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following
        i. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
        ii. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND

iii. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND
iv. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines

There are no preferred agents required for Rituxan Hycela

Prior Authorization Group Description:
Biologic Immunomodulators PA – Ruxience
Drug Name(s)
Ruxience
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ONE of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
2. ALL of the following:
    A. ONE of the following:
        i. Patient has a diagnosis of rheumatoid arthritis AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. Patient has another FDA labeled indication or an indication that is supported in CMS approved compendia AND
    B. Patient has been screened for hepatitis B infection measuring hepatitis B surface antigen (HBsAg) and hepatitis B core antibody (anti-HBc) and has begun therapy, if appropriate, prior to receiving the requested agent AND
    C. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND
    D. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. ONE of the following:

A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
B. Prescriber states the patient is currently being treated with the requested agent OR
C. ALL of the following:
    i. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
    ii. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
    iii. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND
    iv. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines

Use of TWO preferred agents (Cyltezo, Enbrel, Humira, Rinvoq, Xeljanz tablets, or Xeljanz XR) is required for diagnosis of rheumatoid arthritis

ALL other diagnoses do NOT require any preferred agents

Prior Authorization Group Description:
Biologic Immunomodulators PA – Siliq
Drug Name(s)
Siliq
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
        a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Simponi
Drug Name(s)
Simponi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
        a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Humira, or Stelara) is required for diagnosis of ulcerative colitis

Prior Authorization Group Description:
Biologic Immunomodulators PA - Simponi Aria
Drug Name(s)
Simponi Aria
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
        a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of juvenile idiopathic arthritis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Skyrizi
Drug Name(s)
Skyrizi
Skyrizi Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR
    D. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR
    E. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR
    F. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of ONE conventional prerequisite agent is required for diagnoses of Crohn's disease, plaque psoriasis, or psoriatic arthritis

Formulary conventional agents for Crohn’s disease include methotrexate, sulfasalazine, corticosteroids, azathioprine, or mercaptopurine

Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids

Formulary conventional agents for psoriatic arthritis include leflunomide, methotrexate, or sulfasalazine

Prior Authorization Group Description:
Biologic Immunomodulators PA – Sotyktu
Drug Name(s)
Sotyktu
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
        a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Stelara
Drug Name(s)
Stelara
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR
    D. Patient's diagnosis does NOT require a conventional prerequisite agent OR
    E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR
    F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR
    G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of ONE conventional prerequisite agent is required for diagnoses of psoriatic arthritis, plaque psoriasis, moderate ulcerative colitis, or Crohn's disease

NO prerequisites are required for diagnosis of severe ulcerative colitis

Formulary conventional agents for psoriatic arthritis include cyclosporine, leflunomide, methotrexate, or sulfasalazine

Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids

Formulary conventional agents for Crohn's disease include methotrexate, sulfasalazine, corticosteroids, azathioprine, mercaptopurine

Formulary conventional agents for moderate ulcerative colitis include 5-aminosalicylates, corticosteroids, azathioprine, mercaptopurine

Prior Authorization Group Description:
Biologic Immunomodulators PA – Taltz
Drug Name(s)
Taltz
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
        a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Rinvoq, Skyrizi, Stelara, Tremfya, Xeljanz tablets, or Xeljanz XR) is required for diagnosis of psoriatic arthritis

For patients 18 years of age or over, use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

For patients between 12 and less than 18 years of age, use of TWO preferred agents (Cosentyx, Enbrel, or Stelara) is required for diagnosis of plaque psoriasis

For patients between 6 and less than 12 years of age, use of TWO preferred agents (Cosentyx, Enbrel, or Stelara) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Rinvoq, Xeljanz tablets, or Xeljanz XR) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cosentyx and Rinvoq) is required for diagnosis of non-radiographic axial spondyloarthritis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Tremfya
Drug Name(s)
Tremfya
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR
    D. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR
    E. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR
    F. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of ONE conventional prerequisite agent is required for diagnoses of psoriatic arthritis or plaque psoriasis

Formulary conventional agents for psoriatic arthritis include cyclosporine, leflunomide, methotrexate, or sulfasalazine

Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids

Prior Authorization Group Description:
Biologic Immunomodulators PA - Truxima
Drug Name(s)
Truxima
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ONE of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
2. ALL of the following:
    A. ONE of the following:
        i. Patient has a diagnosis of rheumatoid arthritis AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. Patient has another FDA labeled indication or an indication that is supported in CMS approved compendia AND
    B. Patient has been screened for hepatitis B infection measuring hepatitis B surface antigen (HBsAg) and hepatitis B core antibody (anti-HBc) and has begun therapy, if appropriate, prior to receiving the requested agent AND
    C. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND
    D. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. ONE of the following:

A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
B. Prescriber states the patient is currently being treated with the requested agent OR
C. ALL of the following:
    i. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
    ii. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
    iii. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND
    iv. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines

Use of TWO preferred agents (Cyltezo, Enbrel, Humira, Rinvoq, Xeljanz tablets, or Xeljanz XR) is required for diagnosis of rheumatoid arthritis

ALL other diagnoses do NOT require any preferred agents

Prior Authorization Group Description:
Biologic Immunomodulators PA - Xeljanz Solution
Drug Name(s)
Xeljanz Solution
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's medication history indicates use of preferred TNF agent(s) OR
        ii. Patient has an intolerance or hypersensitivity to preferred TNF agent(s) OR
        iii. Patient has an FDA labeled contraindication to preferred TNF agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of ONE preferred TNF (Cyltezo, Enbrel, or Humira) is required for diagnosis of juvenile idiopathic arthritis

Prior Authorization Group Description:
Biologic Immunomodulators PA - Xeljanz Tablet
Drug Name(s)
Xeljanz Tablet
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's medication history indicates use of preferred TNF agent(s) OR
        ii. Patient has an intolerance or hypersensitivity to preferred TNF agent(s) OR
        iii. Patient has an FDA labeled contraindication to preferred TNF agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of ONE preferred TNF (Cyltezo, Enbrel, or Humira) is required for diagnoses of psoriatic arthritis, rheumatoid arthritis, juvenile idiopathic arthritis, or ankylosing spondylitis

Use of ONE preferred TNF (Cyltezo or Humira) is required for diagnosis of ulcerative colitis

Prior Authorization Group Description:
Biologic Immunomodulators PA - Xeljanz XR
Drug Name(s)
Xeljanz Xr
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's medication history indicates use of preferred TNF agent(s) OR
        ii. Patient has an intolerance or hypersensitivity to preferred TNF agent(s) OR
        iii. Patient has an FDA labeled contraindication to preferred TNF agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of ONE preferred TNF (Cyltezo, Enbrel, or Humira) is required for diagnoses of psoriatic arthritis, rheumatoid arthritis, or ankylosing spondylitis

Use of ONE preferred TNF (Cyltezo or Humira) is required for diagnosis of ulcerative colitis

Prior Authorization Group Description:
Biologic Immunomodulators PA - Yuflyma
Drug Name(s)
Yuflyma Pen Kit
Yuflyma Pen Kit-Cd/Uc/Hs Starter
Yuflyma Syringe Kit
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 12 months

Other Criteria:

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of juvenile idiopathic arthritis

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Humira, Skyrizi, or Stelara) is required for diagnosis of adult Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cyltezo, Humira, or Stelara) is required for diagnosis of ulcerative colitis

Use of ONE preferred agent (Cyltezo or Humira) is required for diagnosis of pediatric Crohn's disease

NO preferred agent is required for diagnosis of adult fistulizing Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, or Humira) is required for diagnosis of hidradenitis suppurativa

Use of TWO preferred agents (Cyltezo and Humira) is required for diagnosis of uveitis

Prior Authorization Group Description:
Biologic Immunomodulators PA - Yusimry
Drug Name(s)
Yusimry Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following:
            a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR
            c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of juvenile idiopathic arthritis

Use of TWO preferred agents (Cyltezo, Enbrel, or Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, or Humira) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cyltezo, Humira, Skyrizi, or Stelara) is required for diagnosis of adult Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Cyltezo, Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cyltezo, Humira, or Stelara) is required for diagnosis of ulcerative colitis

Use of ONE preferred agent (Cyltezo or Humira) is required for diagnosis of pediatric Crohn's disease

NO preferred agent is required for diagnosis of adult fistulizing Crohn's disease

Use of TWO preferred agents (Cosentyx, Cyltezo, or Humira) is required for diagnosis of hidradenitis suppurativa

Use of TWO preferred agents (Cyltezo and Humira) is required for diagnosis of uveitis

Prior Authorization Group Description:
Bivigam/Flebogamma/Gammaplex/Octagam/Privigen PA
Drug Name(s)
Bivigam
Flebogamma Dif
Gammaplex
Octagam
Privigen
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ONE of the following:
1. Patient has ONE of the following diagnoses:
    A. Primary immunodeficiency [e.g., congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency] OR
    B. B-cell chronic lymphocytic leukemia OR multiple myeloma AND ONE of the following:
        i. Patient has a history of infections OR
        ii. Patient has evidence of specific antibody deficiency OR
        iii. Patient has hypogammaglobulinemia OR
    C. Idiopathic thrombocytopenia purpura AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone), or immunosuppressants (e.g., azathioprine)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    D. Dermatomyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone) or immunosuppressants (e.g., azathioprine)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    E. Polymyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone) or immunosuppressants (e.g., azathioprine)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    F. Severe rheumatoid arthritis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., tumor necrosis factor antagonists (e.g., Humira), DMARDS (e.g., methotrexate)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

Criteria continues: see Other Criteria

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 6 months for indications in Other Criteria, 12 months for all others

Other Criteria:

G. Myasthenia gravis (MG) AND ONE of the following:

i. Patient is in acute myasthenic crisis OR

ii. Patient has severe refractory MG (e.g., major functional disability/weakness) AND ONE of the following:

a) Patient has failed ONE immunomodulator therapy (i.e., corticosteroid, pyridostigmine, or azathioprine) OR

b) Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE immunomodulator therapy OR

H. Multiple sclerosis (MS) AND BOTH of the following:

i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND

ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication to TWO MS agents (e.g., Avonex, Betaseron, Copaxone, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Mayzent, Plegridy, teriflunomide, Vumerity) OR

I. Acquired von Willebrand hemophilia AND ONE of the following:

i. Patient has failed ONE conventional therapy (e.g., desmopressin solution, von Willebrand factor replacement therapy, corticosteroids, cyclophosphamide, FEIBA, or recombinant factor VIIa) OR

ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

J. Refractory pemphigus vulgaris AND ONE of the following:

i. Patient has failed ONE conventional immunosuppressive therapy (e.g., azathioprine, cyclophosphamide, mycophenolate, corticosteroids) OR

ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional immunosuppressive therapy OR

2. ONE of the following:

A. Patient has another FDA labeled indication for the requested agent OR

B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Indications with 6 months approval duration: Acquired von Willebrand hemophilia, Guillain-Barre Syndrome, Lambert-Eaton myasthenia syndrome, Kawasaki disease, CMV induced pneumonitis in solid organ transplant, Toxic shock syndrome due to invasive group A streptococcus, Toxic epidermal necrolysis and Stevens-Johnson syndrome

Drug is also subject to Part B versus Part D review.

Prior Authorization Group Description:
Budesonide Oral ER PA – Entocort
Drug Name(s)
Budesonide
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Budesonide Oral ER PA – Uceris
Drug Name(s)
Budesonide Er
Uceris
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Bydureon PA
Drug Name(s)
Bydureon Bcise
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of type 2 diabetes mellitus AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. BOTH of the following:
        i. ONE of the following:
            1. Patient's medication history includes use of an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) within the past 90 days OR
            2. Patient had an ineffective treatment response to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            3. Patient has an intolerance or hypersensitivity to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            4. Patient has an FDA labeled contraindication to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Byetta PA
Drug Name(s)
Byetta
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of type 2 diabetes mellitus AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. BOTH of the following:
        i. ONE of the following:
            1. Patient's medication history includes use of an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) within the past 90 days OR
            2. Patient had an ineffective treatment response to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            3. Patient has an intolerance or hypersensitivity to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            4. Patient has an FDA labeled contraindication to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Bylvay PA
Drug Name(s)
Bylvay
Bylvay (Pellets)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. BOTH of the following:
        i. Patient has a diagnosis of progressive familial intrahepatic cholestasis (PFIC) AND
        ii. The requested agent will be used to treat pruritus OR
    B. BOTH of the following:
        i. Patient has a diagnosis of Alagille Syndrome (ALGS) AND
        ii. The requested agent will be used to treat cholestatic pruritus AND
2. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Camzyos PA
Drug Name(s)
Camzyos
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) AND
2. The requested agent will be used to improve functional capacity and symptoms
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Carglumic PA
Drug Name(s)
Carbaglu
Carglumic Acid
Indications:
All FDA-Approved Indications, Some Medically-Accepted Indications.
Off-Label Uses:
For generic carglumic acid only - Acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA)
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of ONE of the following:
    a. Acute hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) OR
    b. Chronic hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) OR
    c. Acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) AND
2. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist, nephrologist, metabolic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Cayston PA
Drug Name(s)
Cayston
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. Documentation has been provided that indicates the patient has a Pseudomonas aeruginosa respiratory infection AND
3. ONE of the following:
    a. Patient is NOT currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam, inhaled tobramycin) OR
    b. Patient is currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam, inhaled tobramycin) AND ONE of the following:
        i. Prescriber has confirmed that the other inhaled antibiotic will be discontinued, and that therapy will be continued only with the requested agent OR
        ii. Prescriber has provided information in support of another inhaled antibiotic therapy used concurrently with or alternating with (i.e., continuous alternating therapy) the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Chenodal PA
Drug Name(s)
Chenodal
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of radiolucent stones in a well-opacifying gallbladder AND
2. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Chorionic Gonadotropin PA
Drug Name(s)
Chorionic Gonadotropin
Novarel
Pregnyl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used to promote fertility AND requested agent will be used to treat erectile dysfunction AND FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of prepubertal cryptorchidism not due to anatomic obstruction OR
    B. Patient's sex is male, with a diagnosis of hypogonadotropic hypogonadism (hypogonadism secondary to pituitary deficiency) AND BOTH of the following:
        i. Patient has a measured current or pretreatment total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR a free serum testosterone level that is below the testing laboratory's lower limit of the normal range AND
        ii. Patient has measured luteinizing hormone (LH) AND follicle-stimulating hormone (FSH) levels that are at (low-normal) or below the testing laboratory's normal range OR
    C. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Cibinqo PA
Drug Name(s)
Cibinqo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of moderate-to-severe atopic dermatitis AND BOTH of the following:
    A. ONE of the following:
        i. Patient has tried and failed a topical steroid (e.g., triamcinolone) OR
        ii. Patient has an intolerance or hypersensitivity to a topical steroid OR
        iii. Patient has an FDA labeled contraindication to a topical steroid AND
    B. ONE of the following:
        i. Patient has tried and failed a topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus) OR
        ii. Patient has an intolerance or hypersensitivity to a topical calcineurin inhibitor OR
        iii. Patient has an FDA labeled contraindication to a topical calcineurin inhibitor AND
2. Patient will NOT be using the requested agent in combination with other biologic immunomodulator agents, other JAK inhibitors, OR other immunosuppressants

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of moderate-to-severe atopic dermatitis AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with other biologic immunomodulator agents, other JAK inhibitors, OR other immunosuppressants
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, dermatologist, immunologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Cinacalcet PA
Drug Name(s)
Cinacalcet Hydrochloride
Sensipar
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has ONE of the following:
    A. A diagnosis of hypercalcemia due to parathyroid carcinoma OR
    B. A diagnosis of primary hyperparathyroidism (HPT) AND BOTH of the following:
        i. Patient has a pretreatment serum calcium level that is above the testing laboratory's upper limit of normal AND
        ii. Patient is unable to undergo parathyroidectomy OR
    C. Another indication that is FDA approved or supported in CMS approved compendia for the requested agent not otherwise excluded from Part D [i.e., secondary hyperparathyroidism due to end-stage renal disease (ESRD) on dialysis]
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Cinqair PA
Drug Name(s)
Cinqair
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of severe asthma with an eosinophilic phenotype AND
2. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent AND
3. Patient will NOT be using the requested agent in combination with Xolair, Dupixent, or with another injectable interleukin 5 (IL-5) inhibitor (e.g., Fasenra, Nucala) for the requested indication AND
4. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of severe asthma with an eosinophilic phenotype
AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent AND
5. Patient will NOT be using the requested agent in combination with Xolair, Dupixent, or with another injectable interleukin 5 (IL-5) inhibitor (e.g., Fasenra, Nucala) for the requested indication AND
6. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Patient is 18 years of age or over
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Fulphila
Drug Name(s)
Fulphila
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Fylnetra
Drug Name(s)
Fylnetra
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Granix
Drug Name(s)
Granix
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Leukine
Drug Name(s)
Leukine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Neulasta
Drug Name(s)
Neulasta
Neulasta Onpro Kit
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    i. Patient has an FDA labeled or CMS compendia supported indication for the requested agent that is not indicated for ONE preferred agent OR
    ii. Patient has tried and had an inadequate response to ONE preferred agent OR
    iii. Patient has an intolerance or hypersensitivity to ONE preferred agent OR
    iv. Patient has an FDA labeled contraindication to ONE preferred agent OR
    v. Prescriber has provided information in support of the use of the non-preferred agent over ONE preferred agent

Preferred agent(s) are Fulphila, Fylnetra, Granix, Nivestym, Nyvepria, Releuko, Stimufend, Udenyca, Zarxio, Ziextenzo
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Neupogen
Drug Name(s)
Neupogen
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    i. Patient has an FDA labeled or CMS compendia supported indication for the requested agent that is not indicated for ONE preferred agent OR
    ii. Patient has tried and had an inadequate response to ONE preferred agent OR
    iii. Patient has an intolerance or hypersensitivity to ONE preferred agent OR
    iv. Patient has an FDA labeled contraindication to ONE preferred agent OR
    v. Prescriber has provided information in support of the use of the non-preferred agent over ONE preferred agent

Preferred agent(s) are Fulphila, Fylnetra, Granix, Nivestym, Nyvepria, Releuko, Stimufend, Udenyca, Zarxio, Ziextenzo
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Nivestym
Drug Name(s)
Nivestym
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Nyvepria
Drug Name(s)
Nyvepria
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Releuko
Drug Name(s)
Releuko
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Rolvedon
Drug Name(s)
Rolvedon
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Stimufend
Drug Name(s)
Stimufend
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Udenyca
Drug Name(s)
Udenyca
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Zarxio
Drug Name(s)
Zarxio
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Colony Stimulating Factors PA – Ziextenzo
Drug Name(s)
Ziextenzo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Concerta PA
Drug Name(s)
Concerta
Methylphenidate Hydrochloride Er (Concerta)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Corlanor PA
Drug Name(s)
Corlanor
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has stable, symptomatic chronic heart failure (e.g., NYHA Class II, III, IV: ACCF/AHA Class C, D) AND
2. ONE of following:
    a. ALL of the following:
        i. The requested agent is for a pediatric patient, 6 months of age or over AND
        ii. Patient has heart failure due to dilated cardiomyopathy (DCM) AND
        iii. Patient is in sinus rhythm with an elevated heart rate OR
    b. ALL of the following:
        i. The requested agent is for an adult patient AND
        ii. Patient has a baseline OR current left ventricular ejection fraction of 35% or less AND
        iii. Patient is in sinus rhythm with a resting heart rate of 70 beats or greater per minute prior to initiating therapy with the requested agent AND
        iv. ONE of the following:
            1. Patient is on a maximally tolerated dose of beta blocker (e.g., bisoprolol, carvedilol, metoprolol) OR
            2. Patient has an intolerance, FDA labeled contraindications, or hypersensitivity to a beta blocker
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Cortrophin Gel PA
Drug Name(s)
Cortrophin
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of nephrotic syndrome AND ONE of the following:
        i. Patient has failed a conventional agent (i.e., prednisone, tacrolimus) for the requested indication OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to a conventional agent OR
    b. Patient has a diagnosis of multiple sclerosis AND ALL of the following:
        i. Patient is experiencing an acute exacerbation AND
        ii. If indicated, there is evidence of a claim that the patient is currently being treated with a disease modifying drug (DMD) within the past 90 days [e.g., Avonex, dimethyl fumarate, glatiramer] to control disease progression OR has an intolerance, FDA labeled contraindication, or hypersensitivity to a DMD AND
        iii. ONE of the following:
            1. Patient has failed corticosteroid therapy (e.g., methylprednisolone) within the last 30 days OR
            2. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to corticosteroid therapy OR

Criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 1 month
Other Criteria:
    c. Patient has a diagnosis of rheumatic disorder (e.g., ankylosing spondylitis, juvenile idiopathic arthritis, juvenile rheumatoid arthritis, psoriatic arthritis, rheumatoid arthritis) AND ALL of the following:
        i. The requested agent will be used as adjunct therapy for short-term administration (to tide the patient over an acute episode or exacerbation) AND
        ii. There is evidence of a claim that the patient is currently being treated with a conventional agent within the past 90 days [e.g., DMARD (methotrexate, leflunomide), biologics (Humira)] to control disease progression AND
        iii. ONE of the following:

1. Patient has failed corticosteroid therapy (e.g., methylprednisolone) within the last 30 days OR
2. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to corticosteroid therapy OR

d. Patient has a diagnosis of systemic lupus erythematosus (SLE) disease AND the patient will continue standard SLE therapy [corticosteroids (e.g., methylprednisolone, prednisone), hydroxychloroquine, immunosuppressives (e.g., azathioprine, methotrexate, oral cyclophosphamide)] in combination with the requested agent OR

e. Patient has another FDA approved indication AND ONE of the following:

i. Patient has failed corticosteroid therapy (e.g., methylprednisolone) within the last 30 days OR

ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to corticosteroid therapy OR

f. Patient has another indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:

i. Patient has failed corticosteroid therapy (e.g., methylprednisolone) within the last 30 days OR

ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to corticosteroid therapy AND

2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Prior Authorization Group Description:
Cotempla PA
Drug Name(s)
Cotempla Xr-Odt
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Cresemba PA
Drug Name(s)
Cresemba
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of invasive aspergillosis OR
    B. Patient has a diagnosis of invasive mucormycosis OR
    C. Patient has another indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of invasive aspergillosis and patient has continued indicators of active disease (e.g., continued radiologic findings, direct microscopy findings, histopathology findings, positive cultures, positive serum galactomannan assay) OR
    B. Patient has a diagnosis of invasive mucormycosis and patient has continued indicators of active disease (e.g., continued radiologic findings, direct microscopy findings, histopathology findings, positive cultures, positive serum galactomannan assay) OR
    C. BOTH of the following:
        i. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Crinone PA
Drug Name(s)
Crinone
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used to treat infertility AND FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Crysvita PA
Drug Name(s)
Crysvita
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. BOTH of the following:
        i. Patient has a diagnosis of X-linked hypophosphatemia (XLH) as confirmed by ONE of the following:
            a. Genetic testing OR
            b. Elevated levels of intact fibroblast growth factor 23 (FGF23) OR
            c. Prescriber has provided information indicating the patient has a positive family history of XLH AND
        ii. ONE of the following:
            a. Patient's epiphyseal plate has not fused OR
            b. Patient's epiphyseal plate has fused AND the patient is experiencing symptoms of XLH (e.g., bone pain, fractures, limited mobility) OR
    B. Patient has a diagnosis of tumor-induced osteomalacia (TIO) associated with phosphaturic mesenchymal tumors AND BOTH of the following:
        i. The requested agent is being used to treat FGF23 related hypophosphatemia AND
        ii. The tumor cannot be curatively surgically resected or localized AND
2. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of X-linked hypophosphatemia (XLH) OR
    B. Patient has a diagnosis of tumor-induced osteomalacia (TIO) associated with phosphaturic mesenchymal tumors AND
3. Patient has had clinical benefit with the requested agent (e.g., enhanced height velocity, improvement in lower extremity bowing and associated abnormalities, radiographic evidence of epiphyseal healing, improvement in bone pain, enhanced mobility, improvement in osteomalacia, improvement in fracture healing) AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent for the requested indication
Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., nephrologist, endocrinologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Cutaquig PA
Drug Name(s)
Cutaquig
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ONE of the following:
1. Patient has ONE of the following diagnoses:
    A. Primary immunodeficiency [e.g., congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency] OR
    B. Multiple sclerosis (MS) AND BOTH of the following:
        i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND
        ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication to TWO MS agents (e.g., Avonex, Betaseron, Copaxone, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Mayzent, Plegridy, teriflunomide, Vumerity) OR
2. ONE of the following:
    A. Patient has another FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Drug is also subject to Part B versus Part D review.
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Cuvrior PA
Drug Name(s)
Cuvrior
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Wilson's disease confirmed by ONE of the following:
    A. Confirmation of genetic mutation of the ATP7B gene OR
    B. Patient has TWO of the following:
        i. Presence of hepatic abnormality (e.g., acute liver failure, cirrhosis, fatty liver)
        ii. Presence of Kayser-Fleischer rings
        iii. Serum ceruloplasmin level less than 20 mg/dL
        iv. Basal urinary copper excretion greater than 40 mcg/24 hours or the testing laboratory's upper limit of normal
        v. Hepatic parenchymal copper content greater than 40 mcg/g dry weight
        vi. Presence of neurological symptoms (e.g., dystonia, hypertonia, rigidity with tremors, dysarthria, muscle spasms, dysphasia, polyneuropathy, dysautonomia) AND
2. Patient is decoppered AND
3. Patient has stable Wilson's disease AND
4. Patient is tolerant of penicillamine

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Wilson's disease AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist, neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Cystadrops PA
Drug Name(s)
Cystadrops
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., ophthalmologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Cystaran PA
Drug Name(s)
Cystaran
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., ophthalmologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Cystinosis Agents PA – Cystagon
Drug Name(s)
Cystagon
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of nephropathic cystinosis AND
2. Prescriber has performed a baseline white blood cell (WBC) cystine level test AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of nephropathic cystinosis AND
3. Patient has had clinical benefit with the requested agent (e.g., decrease in WBC cystine levels from baseline) AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Cystinosis Agents PA – Procysbi
Drug Name(s)
Procysbi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of nephropathic cystinosis AND
2. Prescriber has performed a baseline white blood cell (WBC) cystine level test AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of nephropathic cystinosis AND
3. Patient has had clinical benefit with the requested agent (e.g., decrease in WBC cystine levels from baseline) AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Dalfampridine PA
Drug Name(s)
Ampyra
Dalfampridine Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of multiple sclerosis (MS) AND
2. ONE of the following:
    A. The requested agent will be used in combination with a disease modifying agent [e.g., Aubagio, Avonex, Bafiertam, Betaseron, dimethyl fumarate (e.g., Tecfidera), Extavia, fingolimod, glatiramer (e.g., Copaxone, Glatopa), Kesimpta, Mavenclad, Mayzent, Plegridy, Ponvory, Rebif, Vumerity, Zeposia] OR
    B. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to a disease modifying agent OR
    C. Prescriber has provided information indicating that a disease modifying agent is not clinically appropriate for the patient

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of multiple sclerosis (MS) AND
3. ONE of the following:
    A. The requested agent will be used in combination with a disease modifying agent [e.g., Aubagio, Avonex, Bafiertam, Betaseron, dimethyl fumarate (e.g., Tecfidera), Extavia, fingolimod, glatiramer (e.g., Copaxone, Glatopa), Kesimpta, Mavenclad, Mayzent, Plegridy, Ponvory, Rebif, Tecfidera, Vumerity, Zeposia] OR
    B. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to a disease modifying agent OR
    C. Prescriber has provided information indicating that a disease modifying agent is not clinically appropriate for the patient AND
4. Patient has had improvements or stabilization from baseline in timed walking speed (timed 25-foot walk)
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Initial approval will be for 3 months, renewal approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Daybue PA
Drug Name(s)
Daybue
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require the following:
1. Patient has a diagnosis of Rett syndrome (RTT) with genetic analysis confirming mutation in the MECP2 gene

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Rett syndrome (RTT) AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist, neurologist, pediatrician) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Dayvigo PA
Drug Name(s)
Dayvigo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Deferiprone PA
Drug Name(s)
Deferiprone
Ferriprox
Ferriprox Twice-A-Day
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of transfusional iron overload due to thalassemia syndromes OR
    B. Patient has a diagnosis of transfusional iron overload due to sickle cell disease or other anemias AND
2. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferasirox) for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent for the requested indication
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
DHE 45 PA
Drug Name(s)
Dihydroergotamine Mesylate Inj
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. ONE of the following:
    A. The requested agent will be used for the treatment of acute migraine with or without aura OR
    B. The requested agent will be used for the acute treatment of cluster headache episodes AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to TWO triptan agents with differing active ingredients (e.g., sumatriptan, rizatriptan) OR
    B. Patient has an intolerance or hypersensitivity to TWO triptan agents with differing active ingredients OR
    C. Patient has an FDA labeled contraindication to TWO triptan agents with differing active ingredients AND
3. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, acute CGRP)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. The requested agent will be used for the treatment of acute migraine with or without aura OR
    B. The requested agent will be used for the acute treatment of cluster headache episodes AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, acute CGRP)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Dichlorphenamide PA
Drug Name(s)
Dichlorphenamide
Keveyis
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has a diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, or a related variant
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Doptelet PA
Drug Name(s)
Doptelet
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ONE of the following:
1. Patient has a diagnosis of thrombocytopenia AND ALL of the following:
    A. Patient has chronic liver disease AND
    B. Patient has a platelet count less than 50 X 10^9/L AND
    C. Patient is scheduled to undergo a procedure with an associated risk of bleeding (e.g., gastrointestinal endoscopy, liver biopsy, bronchoscopy, dental procedure) AND
    D. The requested dose is within FDA labeled dosing for the requested indication AND
    E. The length of therapy of the requested agent is within the FDA labeled duration for the requested indication OR
2. Patient has a diagnosis of chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following:
    A. Patient has tried and had an insufficient response to a corticosteroid, another thrombopoietin receptor agonist (e.g., Promacta), or immunoglobulin (IVIg or anti-D) OR
    B. Patient has an intolerance or hypersensitivity to a corticosteroid, another thrombopoietin receptor agonist (e.g., Promacta), or immunoglobulin (IVIg or anti-D) OR
    C. Patient has an FDA labeled contraindication to a corticosteroid, another thrombopoietin receptor agonist (e.g., Promacta), or immunoglobulin (IVIg or anti-D) OR
    D. Patient has had an insufficient response to a splenectomy
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Initial (I) 6 mo ITP, Renewal (R) 12 mo ITP. I & R 1 mo thrombocytopenia w/chronic liver disease
Other Criteria:
Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of thrombocytopenia AND ALL of the following:
        i. Patient has chronic liver disease AND
        ii. Patient has a platelet count less than 50 X 10^9/L AND
        iii. Patient is scheduled to undergo a procedure with an associated risk of bleeding (e.g., gastrointestinal endoscopy, liver biopsy, bronchoscopy, dental procedure) AND
        iv. The requested dose is within FDA labeled dosing for the requested indication AND
        v. The length of therapy of the requested agent is within the FDA labeled duration for the requested indication OR

B. Patient has a diagnosis of chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following:

i. Patient's platelet count is 50 x 10^9/L or greater OR

ii. Patient's platelet count has increased sufficiently to avoid clinically significant bleeding

Prior Authorization Group Description:
Droxidopa PA
Drug Name(s)
Droxidopa
Northera
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of neurogenic orthostatic hypotension (nOH) AND
2. Prescriber has performed baseline blood pressure readings while the patient is sitting or supine (lying face up), AND also within three minutes of standing from a supine position AND
3. Patient has a decrease of at least 20 mmHg in systolic blood pressure or 10 mmHg diastolic blood pressure within three minutes after standing AND
4. Patient has persistent and consistent symptoms of neurogenic orthostatic hypotension (nOH) caused by ONE of the following:
    A. Primary autonomic failure [Parkinson's disease (PD), multiple system atrophy, or pure autonomic failure] OR
    B. Dopamine beta-hydroxylase deficiency OR
    C. Non-diabetic autonomic neuropathy AND
5. Prescriber has assessed the severity of the patient's baseline symptoms of dizziness, lightheadedness, feeling faint, or feeling like the patient may black out AND
6. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of neurogenic orthostatic hypotension (nOH) AND
3. Patient has had improvements or stabilization with the requested agent as indicated by improvement in severity from baseline symptoms of ONE of the following:
    A. Dizziness
    B. Lightheadedness
    C. Feeling faint
    D. Feeling like the patient may black out AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist, neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be 1 month for initial, 3 months for renewal
Other Criteria:

Prior Authorization Group Description:
Dupixent PA
Drug Name(s)
Dupixent
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of moderate-to-severe atopic dermatitis AND ALL of the following:
        i. ONE of the following:
            a. Patient has tried and failed a topical steroid (e.g., triamcinolone) OR
            b. Patient has an intolerance, hypersensitivity, or an FDA labeled contraindication to a topical steroid AND
        ii. For patients 2 years of age or over, ONE of the following:
            a. Patient has tried and failed a topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus) OR
            b. Patient has an intolerance, hypersensitivity, or an FDA labeled contraindication to a topical calcineurin inhibitor AND
        iii. Patient will NOT be using the requested agent in combination with another biologic agent or a JAK inhibitor for the requested indication (e.g., Adbry, Cibinqo, Opzelura, Rinvoq) OR
    B. Patient has a diagnosis of moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid dependent asthma AND BOTH of the following:
        i. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LRTA, LAMA, theophylline) in combination with the requested agent AND
        ii. Patient will NOT be using the requested agent in combination with Xolair or with an injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Fasenra, Nucala) for the requested indication OR
    C. Patient has a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) AND the following:
        i. BOTH of the following:
            a. ONE of the following:
                1. Patient has tried and had an inadequate response to an oral systemic corticosteroid AND an intranasal corticosteroid (e.g., fluticasone) OR
                2. Patient has an intolerance, hypersensitivity, or an FDA labeled contraindication to an oral systemic corticosteroid AND an intranasal corticosteroid AND

Initial criteria continues: see Other Criteria
Age Restriction:

For diagnosis of moderate-to-severe atopic dermatitis, patient is 6 months of age or over. For diagnosis of moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid dependent asthma, patient is 6 years of age or over. For diagnosis of CRSwNP, patient is 18 years of age or over. For diagnosis of EoE, patient is 12 years of age or over. For diagnosis of PN, patient is 18 years of age or over.

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, dermatologist, immunologist, gastroenterologist, otolaryngologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

b. Patient will continue standard maintenance therapy (e.g., intranasal corticosteroid) in combination with the requested agent OR

D. Patient has a diagnosis of eosinophilic esophagitis (EoE) confirmed by esophageal biopsy OR

E. Patient has a diagnosis of prurigo nodularis (PN) AND

2. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND

2. ONE of the following:

A. Patient has a diagnosis of moderate-to-severe atopic dermatitis AND the following:

i. Patient will NOT be using the requested agent in combination with another biologic agent or a JAK inhibitor for the requested indication (e.g., Adbry, Cibinqo, Opzelura, Rinvoq) OR

B. Patient has a diagnosis of moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid dependent asthma AND BOTH of the following:

i. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent AND

ii. Patient will NOT be using the requested agent in combination with Xolair or with an injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Fasenra, Nucala) for the requested indication OR

C. Patient has a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) AND the following:

i. Patient will continue standard maintenance therapy (e.g., intranasal corticosteroid) in combination with the requested agent OR

D. Patient has a diagnosis of eosinophilic esophagitis (EoE) OR

E. Patient has a diagnosis of prurigo nodularis (PN) AND

3. Patient has had clinical benefit with the requested agent AND

4. The requested dose is within FDA labeled dosing for the requested indication

Prior Authorization Group Description:
Elmiron PA
Drug Name(s)
Elmiron
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. The requested agent will be used for the relief of bladder pain or discomfort associated with interstitial cystitis AND
2. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. The requested agent will be used for the relief of bladder pain or discomfort associated with interstitial cystitis AND
3. Patient has had clinical benefit with the requested agent (e.g., decreased bladder pain, decreased frequency or urgency of urination) AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal
Other Criteria:

Prior Authorization Group Description:
Emflaza PA
Drug Name(s)
Emflaza
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) confirmed by ONE of the following:
    A. Presence of abnormal dystrophin OR
    B. Confirmed mutation of the dystrophin gene AND
2. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) AND
3. Patient has had improvement, stabilization of the disease, or clinical benefit from baseline (e.g., improved strength and timed motor function, improved pulmonary function, reduced the need for scoliosis surgery) AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Emgality PA
Drug Name(s)
Emgality
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of migraine AND ALL of the following:
        i. The requested agent is being used for migraine prophylaxis AND
        ii. Patient has 4 migraine headaches or more per month AND
        iii. ONE of the following:
            a. Patient has tried and had an inadequate response to a conventional migraine prophylaxis agent [e.g., beta blockers (propranolol), anticonvulsants (divalproex, topiramate)] OR
            b. Patient has an intolerance, or hypersensitivity to a conventional migraine prophylaxis agent OR
            c. Patient has an FDA labeled contraindication to a conventional migraine prophylaxis agent AND
        iv. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis OR
    B. Patient has a diagnosis of episodic cluster headache AND BOTH of the following:
        i. Patient has had at least 5 cluster headache attacks AND
        ii. Patient has had at least two cluster periods lasting 7 days to one year and separated by pain-free remission periods of 3 months or more

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. ALL of the following:
        i. Patient has a diagnosis of migraine AND
        ii. The requested agent is being used for migraine prophylaxis AND
        iii. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis OR
    B. Patient has a diagnosis of episodic cluster headache AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Emsam PA
Drug Name(s)
Emsam
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of major depressive disorder (MDD) OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. BOTH of the following:
        i. ONE of the following:
            a. BOTH of the following:
                i. Patient has a diagnosis of major depressive disorder (MDD) AND
                ii. ONE of the following:
                    1. Patient has tried and had an inadequate response to at least two different oral antidepressants (e.g., SSRIs, SNRIs, mirtazapine, bupropion) OR
                    2. Patient has an intolerance or hypersensitivity to at least two different oral antidepressants (e.g., SSRIs, SNRIs, mirtazapine, bupropion) OR
                    3. Patient has an FDA labeled contraindication to at least two different oral antidepressants (e.g., SSRIs, SNRIs, mirtazapine, bupropion) OR
            b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:

A. Patient has a diagnosis of major depressive disorder (MDD) OR

B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND

3. ONE of the following:

A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days

OR

B. Prescriber states the patient is currently being treated with the requested agent OR

C. BOTH of the following:

i. Patient has had clinical benefit with the requested agent AND

ii. Patient does NOT have any FDA labeled contraindications to the requested agent

Prior Authorization Group Description:
Endari PA
Drug Name(s)
Endari
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of sickle cell disease AND
2. Patient is using the requested agent to reduce the acute complications of sickle cell disease AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to maximally tolerated dose of hydroxyurea OR
    B. Patient has an intolerance or hypersensitivity to hydroxyurea OR
    C. Patient has an FDA labeled contraindication to hydroxyurea AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Enspryng PA
Drug Name(s)
Enspryng
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of neuromyelitis optica spectrum disorder (NMOSD) AND
2. Patient is anti-aquaporin-4 (AQP4) antibody positive AND
3. Prescriber has screened the patient for hepatitis B viral (HBV) infection and determined to NOT have active hepatitis B viral infection AND
4. Patient does NOT have active or untreated tuberculosis AND
5. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of neuromyelitis optica spectrum disorder (NMOSD) AND
3. Patient has had clinical benefit with the requested agent (e.g., decreased relapses, improvement or stabilization of vision or paralysis) AND
4. Patient does NOT have active hepatitis B virus (HBV) infection AND
5. Patient does NOT have active or untreated tuberculosis AND
6. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Epclusa PA
Drug Name(s)
Epclusa
Sofosbuvir/Velpatasvir
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of hepatitis C confirmed by serological markers OR
    B. Patient is a hepatitis C virus (HCV) - uninfected solid organ transplant recipient AND BOTH of the following:
        i. Patient received an HCV - viremic donor organ AND
        ii. The requested agent is being used for prophylaxis AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The requested dose is within FDA labeled dosing or supported in AASLD/IDSA guideline dosing for the requested indication AND
5. ONE of the following:
    A. The requested agent is the preferred agent: Epclusa OR
    B. The requested agent is the non-preferred agent: sofosbuvir/velpatasvir AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. Patient has an FDA labeled contraindication or hypersensitivity to TWO preferred agents: Epclusa and Harvoni for supported genotypes OR
        iv. Prescriber has provided information based on FDA approved labeling or AASLD/IDSA guidelines supporting the use of the non-preferred agent for the patient's diagnosis and genotype over TWO preferred agents: Epclusa and Harvoni for supported genotypes
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported

Other Criteria:

Prior Authorization Group Description:
Epidiolex PA
Drug Name(s)
Epidiolex
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of seizures associated with ONE of the following:
    A. Lennox-Gastaut syndrome OR
    B. Dravet syndrome OR
    C. Tuberous sclerosis complex AND
2. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Erythropoietin Stimulating Agents PA – Aranesp
Drug Name(s)
Aranesp Albumin Free
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. The requested agent is being prescribed for ONE of the following:
    A. Anemia due to myelosuppressive chemotherapy for a non-myeloid malignancy AND ALL of the following:
        i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR less than 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND
        ii. Patient is being concurrently treated with chemotherapy with or without radiation (treatment period extends to 8 weeks post chemotherapy) AND
        iii. The intent of chemotherapy is non-curative OR
    B. Anemia associated with chronic kidney disease in a patient NOT on dialysis AND ALL of the following:
        i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR 11 g/dL or less for patients stabilized on therapy (measured within the previous 4 weeks) AND
        ii. The rate of hemoglobin decline indicates the likelihood of requiring a RBC transfusion AND
        iii. The intent of therapy is to reduce the risk of alloimmunization and/or other RBC transfusion related risks OR
    C. Anemia due to myelodysplastic syndrome AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) OR
    D. Another indication that is supported in CMS approved compendia for the requested agent AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND
2. Patient's transferrin saturation and serum ferritin have been evaluated

Drug is also subject to Part B versus Part D review.
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
6 months for chemotherapy, 12 months for other indications
Other Criteria:

Prior Authorization Group Description:
Erythropoietin Stimulating Agents PA - Epogen/Procrit
Drug Name(s)
Epogen
Procrit
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. The requested agent is being prescribed for ONE of the following:
    A. To reduce the possibility of allogeneic blood transfusion in a surgery patient AND the patient's hemoglobin level is greater than 10 g/dL but 13 g/dL or less OR
    B. Anemia due to myelosuppressive chemotherapy for a non-myeloid malignancy AND ALL of the following:
        i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR less than 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND
        ii. Patient is being concurrently treated with chemotherapy with or without radiation (treatment period extends to 8 weeks post chemotherapy) AND
        iii. The intent of chemotherapy is non-curative OR
    C. Anemia associated with chronic kidney disease in a patient NOT on dialysis AND ALL of the following:
        i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR 11 g/dL or less for patients stabilized on therapy (measured within the previous 4 weeks) AND
        ii. The rate of hemoglobin decline indicates the likelihood of requiring a RBC transfusion AND
        iii. The intent of therapy is to reduce the risk of alloimmunization and/or other RBC transfusion related risks OR
    D. Anemia due to myelodysplastic syndrome AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) OR
    E. Anemia resulting from zidovudine treatment of HIV infection AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks)
    OR

Initial criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

1 month for surgery (reduce transfusion possibility), 6 months for chemo, 12 months for other

Other Criteria:

F. Another indication that is supported in CMS approved compendia for the requested agent AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND

2. Patient's transferrin saturation and serum ferritin have been evaluated

Drug is also subject to Part B versus Part D review.

Prior Authorization Group Description:
Erythropoietin Stimulating Agents PA – Retacrit
Drug Name(s)
Retacrit
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. The requested agent is being prescribed for ONE of the following:
    A. To reduce the possibility of allogeneic blood transfusion in a surgery patient AND the patient's hemoglobin level is greater than 10 g/dL but 13 g/dL or less OR
    B. Anemia due to myelosuppressive chemotherapy for a non-myeloid malignancy AND ALL of the following:
        i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR less than 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND
        ii. Patient is being concurrently treated with chemotherapy with or without radiation (treatment period extends to 8 weeks post chemotherapy) AND
        iii. The intent of chemotherapy is non-curative OR
    C. Anemia associated with chronic kidney disease in a patient NOT on dialysis AND ALL of the following:
        i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR 11 g/dL or less for patients stabilized on therapy (measured within the previous 4 weeks)
        AND
        ii. The rate of hemoglobin decline indicates the likelihood of requiring a RBC transfusion AND
        iii. The intent of therapy is to reduce the risk of alloimmunization and/or other RBC transfusion related risks OR
    D. Anemia resulting from zidovudine treatment of HIV infection AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks)
    OR
    E. Another indication that is supported in CMS approved compendia for the requested agent AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND
2. Patient's transferrin saturation and serum ferritin have been evaluated

Drug is also subject to Part B versus Part D review.
Age Restriction:

Prescriber Restrictions:
Coverage Duration:
1 month for surgery (reduce transfusion possibility), 6 months for chemo, 12 months for other
Other Criteria:

Prior Authorization Group Description:
Evenity PA
Drug Name(s)
Evenity
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient is postmenopausal with a diagnosis of osteoporosis AND BOTH of the following:
    A. Patient's diagnosis was confirmed by ONE of the following:
        i. A fragility fracture in the hip or spine OR
        ii. A T-score of -2.5 or lower OR
        iii. A T-score of -1.0 to -2.5 AND ONE of the following:
            a. A fragility fracture of the proximal humerus, pelvis, or distal forearm OR
            b. A FRAX 10-year probability for major osteoporotic fracture of 20% or greater OR
            c. A FRAX 10-year probability of hip fracture of 3% or greater AND
    B. ONE of the following:
        i. Patient is at a very high fracture risk as defined by ONE of the following:
            a. Patient had a recent fracture (within the past 12 months) OR
            b. Patient had fractures while on FDA approved osteoporosis therapy OR
            c. Patient has had multiple fractures OR
            d. Patient had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR
            e. Patient has a very low T-score (less than -3.0) OR
            f. Patient is at high risk for falls or has a history of injurious falls OR
            g. Patient has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm OR
        ii. ONE of the following:
            a. Patient has tried and had an inadequate response to a bisphosphonate OR
            b. Patient has an intolerance or hypersensitivity to a bisphosphonate OR
            c. Patient has an FDA labeled contraindication to a bisphosphonate AND

Criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
No prior use approve 12 months, Prior use approve remainder of 12 months of total cumulative therapy
Other Criteria:
2. ONE of the following:

A. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR
B. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR
C. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) AND

3. Patient will NOT be using the requested agent in combination with a bisphosphonate, denosumab (e.g., Prolia, Xgeva), or parathyroid hormone analog (e.g., abaloparatide, teriparatide) for the requested indication AND
4. The requested dose is within FDA labeled dosing for the requested indication AND
5. The total cumulative duration of treatment with Evenity (romosozumab-aqqg) has not exceeded 12 months

Prior Authorization Group Description:
Evkeeza PA
Drug Name(s)
Evkeeza
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) AND
2. ONE of the following:
    A. Genetic confirmation of two mutant alleles at the LDLR, Apo-B, PCSK9, or LDLRAP1 gene OR
    B. History of untreated LDL-C greater than 500 mg/dL (greater than 13 mmol/L) or treated LDL-C 300 mg/dL or greater (7.76 mmol/L or greater) OR
    C. Patient has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma) AND
3. ONE of the following:
    A. Patient is currently being treated with a lipid-lowering regimen in the past 90 days (i.e., rosuvastatin in combination with ezetimibe, atorvastatin in combination with ezetimibe, OR PCSK9) OR
    B. Patient has an intolerance or hypersensitivity to a lipid-lowering regimen (i.e., rosuvastatin in combination with ezetimibe, atorvastatin in combination with ezetimibe, OR PCSK9) OR
    C. Patient has an FDA labeled contraindication to a lipid-lowering regimen (i.e., rosuvastatin in combination with ezetimibe, atorvastatin in combination with ezetimibe, OR PCSK9) AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Patient is within FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist, endocrinologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) AND
3. Patient has had clinical benefit with the requested agent AND
4. ONE of the following:
    A. Patient is currently being treated with a lipid-lowering regimen in the past 90 days (i.e., rosuvastatin in combination with ezetimibe, atorvastatin in combination with ezetimibe, OR PCSK9) OR

B. Patient has an intolerance or hypersensitivity to a lipid-lowering regimen (i.e., rosuvastatin in combination with ezetimibe, atorvastatin in combination with ezetimibe, OR PCSK9)
OR
C. Patient has an FDA labeled contraindication to a lipid-lowering regimen (i.e., rosuvastatin in combination with ezetimibe, atorvastatin in combination with ezetimibe, OR PCSK9)
AND

5. The requested dose is within FDA labeled dosing for the requested indication

Prior Authorization Group Description:
Evrysdi PA
Drug Name(s)
Evrysdi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require the following:
1. Patient has a diagnosis of Spinal Muscular Atrophy (SMA) as confirmed by genetic testing

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Spinal Muscular Atrophy (SMA) AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist, geneticist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Eysuvis PA
Drug Name(s)
Eysuvis
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of dry eye disease AND
2. The requested agent will be used for short-term (up to two weeks) treatment AND
3. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 1 month
Other Criteria:

Prior Authorization Group Description:
Fasenra PA
Drug Name(s)
Fasenra
Fasenra Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of severe asthma with an eosinophilic phenotype AND
2. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent AND
3. Patient will NOT be using the requested agent in combination with Xolair, Dupixent, or with another injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Nucala) for the requested indication AND
4. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of severe asthma with an eosinophilic phenotype AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent AND
5. Patient will NOT be using the requested agent in combination with Xolair, Dupixent, or with another injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Nucala) for the requested indication AND
6. The requested dose is within the FDA labeled dosing for the requested indication
Age Restriction:
Patient is 12 years of age or over
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Fentanyl Nasal PA - Lazanda
Drug Name(s)
Lazanda
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a documented diagnosis (i.e., medical records) of chronic cancer pain due to an active malignancy AND the following:
        i. There is evidence of a claim that the patient is currently being treated with a long-acting opioid with the requested agent within the past 90 days OR
    b. Patient has a diagnosis that is supported in CMS approved compendia for the requested agent AND
2. Patient will NOT be using the requested agent in combination with any other oral or nasal fentanyl agent
Age Restriction:
Patient is 18 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Fentanyl Oral PA - Fentanyl lozenge
Drug Name(s)
Actiq
Fentanyl Citrate Oral Transmucosal
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a documented diagnosis (i.e., medical records) of chronic cancer pain due to an active malignancy AND the following:
        i. There is evidence of a claim that the patient is currently being treated with a long-acting opioid with the requested agent within the past 90 days OR
    b. Patient has a diagnosis that is supported in CMS approved compendia for the requested agent AND
2. Patient will NOT be using the requested agent in combination with any other oral or nasal fentanyl agent
Age Restriction:
Patient is 16 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Fentanyl Oral PA – Fentora
Drug Name(s)
Fentanyl Citrate Tablet
Fentora
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a documented diagnosis (i.e., medical records) of chronic cancer pain due to an active malignancy AND the following:
        i. There is evidence of a claim that the patient is currently being treated with a long-acting opioid with the requested agent within the past 90 days OR
    b. Patient has a diagnosis that is supported in CMS approved compendia for the requested agent AND
2. Patient will NOT be using the requested agent in combination with any other oral or nasal fentanyl agent
Age Restriction:
Patient is 18 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Fentanyl Oral PA – Subsys
Drug Name(s)
Subsys
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a documented diagnosis (i.e., medical records) of chronic cancer pain due to an active malignancy AND the following:
        i. There is evidence of a claim that the patient is currently being treated with a long-acting opioid with the requested agent within the past 90 days OR
    b. Patient has a diagnosis that is supported in CMS approved compendia for the requested agent AND
2. Patient will NOT be using the requested agent in combination with any other oral or nasal fentanyl agent
Age Restriction:
Patient is 18 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Filspari PA
Drug Name(s)
Filspari
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy AND
2. The requested agent will be used to reduce proteinuria AND
3. Patient is at risk of rapid disease progression as shown by ONE of the following:
    A. A urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g OR
    B. Proteinuria greater than or equal to 0.8 g/day AND
4. ONE of the following:
    A. Patient has tried and had an inadequate response with a maximally tolerated ACE or ARB (e.g., benazepril, lisinopril, losartan), or a combination medication containing an ACE or ARB OR
    B. Patient has an intolerance or hypersensitivity to an ACE or ARB, or a combination medication containing an ACE or ARB, that is not expected to occur with the requested agent OR
    C. Patient has an FDA labeled contraindication to an ACE or ARB, or a combination medication containing an ACE or ARB, that is not expected to occur with the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of primary immunoglobulin A nephropathy (IgAN) AND
3. The requested agent will be used to reduce proteinuria AND
4. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., nephrologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Fintepla PA
Drug Name(s)
Fintepla
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of seizures associated with Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS) AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. An echocardiogram assessment will be obtained before and during treatment with the requested agent, to evaluate for valvular heart disease and pulmonary arterial hypertension AND
        ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND
        iii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Firdapse PA
Drug Name(s)
Firdapse
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. Patient has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) confirmed by at least ONE of the following:
    A. Electrodiagnostic studies (e.g., electromyography) OR
    B. Antibody testing

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is 6 years of age or over
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Focalin PA
Drug Name(s)
Dexmethylphenidate Hydrochloride
Focalin
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Focalin XR PA
Drug Name(s)
Dexmethylphenidate Hydrochloride Er
Focalin Xr
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Galafold PA
Drug Name(s)
Galafold
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Fabry disease AND
2. The diagnosis was confirmed by mutation of alpha-galactosidase A (alpha-gal A) gene
AND
3. Patient has an amenable galactosidase alpha gene (GLA) variant mutation AND
4. Prescriber has evaluated at least ONE of the following: kidney function (e.g., proteinuria, GFR), cardiac function (e.g., left ventricular hypertrophy, conduction or rhythm, mitral or aortic insufficiency), optic neuropathy, neuropathic pain, and/or gastrointestinal symptoms

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Fabry disease AND
3. Patient has had clinical benefit with the requested agent [e.g., improvement or stabilization of at least ONE of the following: kidney function (e.g., proteinuria, GFR), cardiac function (e.g., left ventricular hypertrophy, conduction or rhythm, mitral or aortic insufficiency), optic neuropathy, neuropathic pain, gastrointestinal symptoms]
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, geneticist, nephrologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Gamastan PA
Drug Name(s)
Gamastan
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ONE of the following:
1. Patient has ONE of the following diagnoses:
    A. Primary immunodeficiency [e.g., congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency] OR
    B. Multiple sclerosis (MS) AND BOTH of the following:
        i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND
        ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication to TWO MS agents (e.g., Avonex, Betaseron, Copaxone, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Mayzent, Plegridy, teriflunomide, Vumerity) OR
    C. Hepatitis A infection prophylaxis AND exposure occurred within the past 2 weeks OR
    D. Measles (rubeola) prophylaxis AND BOTH of the following:
        i. Patient is considered susceptible to infection (a susceptible person is defined as one who has not been vaccinated and has not had measles previously) AND
        ii. Patient was exposed to measles (rubeola) within the past 6 days OR
    E. Passive immunization against varicella AND BOTH of the following:
        i. Patient is immunocompromised AND
        ii. Varicella-Zoster immune globulin is unavailable OR
    F. Rubella prophylaxis in exposed pregnant woman AND the patient is considered susceptible to infection (a susceptible person is defined as one who has not been vaccinated and has not had rubella previously) OR
2. ONE of the following:
A. Patient has another FDA labeled indication for the requested agent OR
B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
For prophylaxis diagnoses: see Other Criteria, for all other diagnoses 12 months
Other Criteria:
Prophylaxis indication with 3 months approval: Hepatitis A infection prophylaxis

Prophylaxis indications with 1 month approval: measles (rubeola) prophylaxis, passive immunization against varicella, rubella prophylaxis in exposed pregnant woman

Prior Authorization Group Description:
Gammagard/Gammaked/Gamunex-C PA
Drug Name(s)
Gammagard Liquid
Gammagard S/D Iga Less Than 1Mcg/Ml
Gammaked
Gamunex-C
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ONE of the following:
1. Patient has ONE of the following diagnoses:
    A. Primary immunodeficiency [e.g., congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency] OR
    B. B-cell chronic lymphocytic leukemia OR multiple myeloma AND ONE of the following:
        i. Patient has a history of infections OR
        ii. Patient has evidence of specific antibody deficiency OR
        iii. Patient has hypogammaglobulinemia OR
    C. Idiopathic thrombocytopenia purpura AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone), or immunosuppressants (e.g., azathioprine)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    D. Dermatomyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone) or immunosuppressants (e.g., azathioprine)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    E. Polymyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone) or immunosuppressants (e.g., azathioprine)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    F. Severe rheumatoid arthritis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., tumor necrosis factor antagonists (e.g., Humira), DMARDS (e.g., methotrexate)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

Criteria continues: see Other Criteria

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 6 months for indications in Other Criteria, 12 months for all others

Other Criteria:

G. Myasthenia gravis (MG) AND ONE of the following:

i. Patient is in acute myasthenic crisis OR

ii. Patient has severe refractory MG (e.g., major functional disability/weakness) AND ONE of the following:

a) Patient has failed ONE immunomodulator therapy (i.e., corticosteroid, pyridostigmine, or azathioprine) OR

b) Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE immunomodulator therapy OR

H. Multiple sclerosis (MS) AND BOTH of the following:

i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND

ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication to TWO MS agents (e.g., Avonex, Betaseron, Copaxone, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Mayzent, Plegridy, teriflunomide, Vumerity) OR

I. Acquired von Willebrand hemophilia AND ONE of the following:

i. Patient has failed ONE conventional therapy (e.g., desmopressin solution, von Willebrand factor replacement therapy, corticosteroids, cyclophosphamide, FEIBA, or recombinant factor VIIa) OR

ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

J. Refractory pemphigus vulgaris AND ONE of the following:

i. Patient has failed ONE conventional immunosuppressive therapy (e.g., azathioprine, cyclophosphamide, mycophenolate, corticosteroids) OR

ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional immunosuppressive therapy OR

2. ONE of the following:

A. Patient has another FDA labeled indication for the requested agent OR

B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Indications with 6 months approval duration: Acquired von Willebrand hemophilia, Guillain-Barre Syndrome, Lambert-Eaton myasthenia syndrome, Kawasaki disease, CMV induced pneumonitis in solid organ transplant, Toxic shock syndrome due to invasive group A streptococcus, Toxic epidermal necrolysis and Stevens-Johnson syndrome

Drug is also subject to Part B versus Part D review.

Prior Authorization Group Description:
Gattex PA
Drug Name(s)
Gattex
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of short bowel syndrome (SBS) AND
2. Patient is dependent on parenteral nutrition OR intravenous (PN/IV) fluids AND
3. ONE of the following:
    A. Patient is aged 1 year to 17 years AND BOTH of the following:
        i. A fecal occult blood test has been performed within 6 months prior to initiating treatment with the requested agent AND
        ii. ONE of the following:
            a. There was no unexplained blood in the stool OR
            b. There was unexplained blood in the stool AND a colonoscopy or a sigmoidoscopy was performed OR
    B. Patient is 18 years of age or over AND BOTH of the following:
        i. Patient has had a colonoscopy within 6 months prior to initiating treatment with the requested agent AND
        ii. If polyps were present at this colonoscopy, the polyps were removed AND
4. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of short bowel syndrome (SBS) AND
3. Patient has had a reduction from baseline in parenteral nutrition OR intravenous (PN/IV) fluids AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal
Other Criteria:

Prior Authorization Group Description:
Gaucher Enzyme Replacement PA – Cerezyme
Drug Name(s)
Cerezyme
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Gaucher disease type 1 (GD1) confirmed by ONE of the following:
    A. A baseline glucocerebrosidase enzyme activity of less than or equal to 15% of mean normal in peripheral blood leukocytes, fibroblasts, or other nucleated cells OR
    B. Confirmation of genetic mutation of GBA gene with two disease-causing alleles AND
2. Prescriber has drawn baseline measurements of hemoglobin, platelet count, liver volume, and spleen volume AND
3. Prior to any treatment for the intended diagnosis, the patient has had at least ONE of the following clinical presentations:
    A. Anemia [defined as mean hemoglobin (Hb) level below the testing laboratory's lower limit of the normal range based on age and gender] OR
    B. Thrombocytopenia (defined as a platelet count of less than 100,000 per microliter) OR
    C. Hepatomegaly OR
    D. Splenomegaly OR
    E. Growth failure (i.e., growth velocity below the standard mean for age) OR
    F. Evidence of bone disease with other causes ruled out

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Gaucher disease type 1 (GD1) AND
3. Patient has had improvement and/or stabilization from baseline in at least ONE of the following:
    A. Hemoglobin (Hb) level OR
    B. Platelet count OR
    C. Liver volume OR
    D. Spleen volume OR
    E. Growth velocity OR
    F. Bone pain or disease
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, geneticist, hematologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Gaucher Enzyme Replacement PA – Elelyso
Drug Name(s)
Elelyso
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Gaucher disease type 1 (GD1) confirmed by ONE of the following:
    A. A baseline glucocerebrosidase enzyme activity of less than or equal to 15% of mean normal in peripheral blood leukocytes, fibroblasts, or other nucleated cells OR
    B. Confirmation of genetic mutation of GBA gene with two disease-causing alleles AND
2. Prescriber has drawn baseline measurements of hemoglobin, platelet count, liver volume, and spleen volume AND
3. Prior to any treatment for the intended diagnosis, the patient has had at least ONE of the following clinical presentations:
    A. Anemia [defined as mean hemoglobin (Hb) level below the testing laboratory's lower limit of the normal range based on age and gender] OR
    B. Thrombocytopenia (defined as a platelet count of less than 100,000 per microliter) OR
    C. Hepatomegaly OR
    D. Splenomegaly OR
    E. Growth failure (i.e., growth velocity below the standard mean for age) OR
    F. Evidence of bone disease with other causes ruled out

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Gaucher disease type 1 (GD1) AND
3. Patient has had improvement and/or stabilization from baseline in at least ONE of the following:
    A. Hemoglobin (Hb) level OR
    B. Platelet count OR
    C. Liver volume OR
    D. Spleen volume OR
    E. Growth velocity OR
    F. Bone pain or disease
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, geneticist, hematologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Gaucher Enzyme Replacement PA – Vpriv
Drug Name(s)
Vpriv
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Gaucher disease type 1 (GD1) confirmed by ONE of the following:
    A. A baseline glucocerebrosidase enzyme activity of less than or equal to 15% of mean normal in peripheral blood leukocytes, fibroblasts, or other nucleated cells OR
    B. Confirmation of genetic mutation of GBA gene with two disease-causing alleles AND
2. Prescriber has drawn baseline measurements of hemoglobin, platelet count, liver volume, and spleen volume AND
3. Prior to any treatment for the intended diagnosis, the patient has had at least ONE of the following clinical presentations:
    A. Anemia [defined as mean hemoglobin (Hb) level below the testing laboratory's lower limit of the normal range based on age and gender] OR
    B. Thrombocytopenia (defined as a platelet count of less than 100,000 per microliter) OR
    C. Hepatomegaly OR
    D. Splenomegaly OR
    E. Growth failure (i.e., growth velocity below the standard mean for age) OR
    F. Evidence of bone disease with other causes ruled out

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Gaucher disease type 1 (GD1) AND
3. Patient has had improvement and/or stabilization from baseline in at least ONE of the following:
    A. Hemoglobin (Hb) level OR
    B. Platelet count OR
    C. Liver volume OR
    D. Spleen volume OR
    E. Growth velocity OR
    F. Bone pain or disease
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, geneticist, hematologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Gralise PA
Drug Name(s)
Gralise
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of Postherpetic Neuralgia (PHN) AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to immediate-release gabapentin OR
    B. Patient has an intolerance or hypersensitivity to immediate-release gabapentin OR
    C. Patient has an FDA labeled contraindication to immediate-release gabapentin that is not expected to occur with the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Postherpetic Neuralgia (PHN) AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Growth Hormone PA – Genotropin
Drug Name(s)
Genotropin
Genotropin Miniquick
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
For Children – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of Turner Syndrome OR
    b. Patient has a diagnosis of Prader-Willi Syndrome OR
    c. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR
    d. Patient has a diagnosis of growth hormone deficiency (GHD) or short stature AND BOTH of the following:
        i. ONE of the following:
            a) Height more than 2 standard deviations (SD) below the mean for age and sex OR
            b) Height more than 1.5 SD below the midparental height OR
            c) A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over two years AND
        ii. Failure of at least 2 GH stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab) OR
    e. Patient has a diagnosis of small for gestational age (SGA) AND ALL of the following:
        i. Patient is at least 2 years of age AND
        ii. Documented birth weight and/or length that is 2 or more standard deviations (SD) below the mean for gestational age AND
        iii. At 24 months of age, the patient fails to manifest catch-up growth evidenced by a height that remains 2 or more SD below the mean for age and sex AND
2. ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 12 months

Other Criteria:

For Children – Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Growth Hormone Deficiency, Short Stature OR
    b. Panhypopituitarism OR
    c. Prader-Willi Syndrome OR
    d. Small for Gestational Age OR
    e. Turner Syndrome AND
3. ALL of the following:
    a. Patient does NOT have closed epiphyses AND
    b. Patient is being monitored for adverse effects of therapy with the requested agent AND
    c. Patient's height has increased or height velocity has improved since initiation or last approval of the requested agent

For Adults – Criteria for initial approval require BOTH of the following:

1. ONE of the following:
    a. Patient has a diagnosis of childhood growth hormone deficiency (GHD) with genetic or organic origin AND ONE of the following:
        i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR
        ii. Failure of at least one growth hormone (GH) stimulation test as an adult (e.g., peak GH value of 5 mcg/L or lower after stimulation, or otherwise considered abnormal as determined by testing lab) OR
    b. Patient has a diagnosis of acquired adult GHD secondary to structural lesions or trauma AND ONE of the following:
        i. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
            a) Deficiencies in 3 or more pituitary axes AND
            b) Low IGF-1 level without GH replacement therapy OR
        ii. Patient has failed at least one GH stimulation test as an adult OR
    c. Patient has a diagnosis of idiopathic GHD (adult or childhood onset) AND the patient has failed at least two growth hormone (GH) stimulation tests as an adult AND
2. ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

For Adults – Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Childhood growth hormone deficiency (GHD) with genetic or organic origin OR
    b. Acquired adult GHD secondary to structural lesions or trauma OR

c. Idiopathic GHD (adult or childhood onset) AND

3. Patient is being monitored for adverse effects of therapy with the requested agent AND
4. Patient's IGF-1 level has been evaluated to confirm the appropriateness of the current dose AND
5. Patient has had clinical benefit with the requested agent (i.e., body composition, hip-to-waist ratio, cardiovascular health, bone mineral density, serum cholesterol, physical strength, or quality of life)

Prior Authorization Group Description:
Growth Hormone PA – Humatrope
Drug Name(s)
Humatrope
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
For Children – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of Turner Syndrome* OR
    b. Patient has a diagnosis of SHOX gene deficiency OR
    c. Patient has a diagnosis of panhypopituitarism* AND BOTH of the following:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR
    d. Patient has a diagnosis of growth hormone deficiency (GHD)* or short stature* AND BOTH of the following:
        i. ONE of the following:
            a) Height more than 2 standard deviation (SD) below the mean for age and sex OR
            b) Height more than 1.5 SD below the midparental height OR
            c) A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over 2 years AND
        ii. Failure of at least 2 GH stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab) OR
    e. Patient has a diagnosis of small for gestational age* AND ALL of the following:
        i. Patient is at least 2 years of age AND
        ii. Documented birth weight and/or length that is 2 or more SD below the mean for gestational age AND
        iii. At 24 months of age, the patient fails to manifest catch-up growth evidenced by a height that remains 2 or more SD below the mean for age and sex AND
2. Patient's diagnosis is indicated in the preferred GH agent AND ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

NOTE:
*Use of the preferred agent [Omnitrope] is required
NO prerequisites are required for the diagnosis of SHOX gene deficiency

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
For Children – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Growth Hormone Deficiency, Short Stature OR
    b. Panhypopituitarism OR
    c. Small for Gestational Age OR
    d. SHOX gene deficiency OR
    e. Turner Syndrome AND
3. ALL of the following:
    a. Patient does NOT have closed epiphyses AND
    b. Patient is being monitored for adverse effects of therapy with the requested agent AND
    c. Patient's height has increased or height velocity has improved since initiation or last approval of the requested agent

For Adults – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of childhood growth hormone deficiency (GHD) with genetic or organic origin AND ONE of the following:
        i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR
        ii. Failure of at least one growth hormone (GH) stimulation test as an adult (e.g., peak GH value of 5 mcg/L or lower after stimulation, or otherwise considered abnormal as determined by testing lab) OR
    b. Patient has a diagnosis of acquired adult GHD secondary to structural lesions or trauma AND ONE of the following:
        i. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
            a) Deficiencies in 3 or more pituitary axes AND
            b) Low IGF-1 level without GH replacement therapy OR
        ii. Patient has failed at least one growth hormone (GH) stimulation test as an adult OR
    c. Patient has a diagnosis of idiopathic GHD (adult or childhood onset) AND the patient has failed at least two GH stimulation tests as an adult AND
2. ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

For Adults – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND

2. Patient has been diagnosed with ONE of the following:
    a. Childhood growth hormone deficiency (GHD) with genetic or organic origin OR
    b. Acquired adult GHD secondary to structural lesions or trauma OR
    c. Idiopathic GHD (adult or childhood onset) AND
3. Patient is being monitored for adverse effects of therapy with the requested agent AND
4. Patient's IGF-1 level has been evaluated to confirm the appropriateness of the current dose AND
5. Patient has had clinical benefit with the requested agent (i.e., body composition, hip-to-waist ratio, cardiovascular health, bone mineral density, serum cholesterol, physical strength, or quality of life)

Prior Authorization Group Description:
Growth Hormone PA – Ngenla
Drug Name(s)
Ngenla
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
For Children – Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of growth hormone deficiency (GHD), short stature, or growth failure due to inadequate secretion of endogenous growth hormone AND BOTH of the following:
    a. ONE of the following:
        i. Height more than 2 standard deviations (SD) below the mean for age and sex OR
        ii. Height more than 1.5 SD below the midparental height OR
        iii. A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
        iv. Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over two years AND
    b. Failure of at least 2 GH stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab) AND
2. ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

For Children – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of growth hormone deficiency (GHD), short stature, or growth failure due to inadequate secretion of endogenous growth hormone AND
3. ALL of the following:
    a. Patient does NOT have closed epiphyses AND
    b. Patient is being monitored for adverse effects of therapy with the requested agent AND
    c. Patient's height has increased or height velocity has improved since initiation or last approval of the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Growth Hormone PA – Norditropin
Drug Name(s)
Norditropin Flexpro
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
For Children – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of Turner Syndrome* OR
    b. Patient has a diagnosis of Prader-Willi Syndrome* OR
    c. Patient has a diagnosis of Noonan Syndrome OR
    d. Patient has a diagnosis of panhypopituitarism* AND BOTH of the following:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR
    e. Patient has a diagnosis of growth hormone deficiency (GHD)* or short stature* AND BOTH of the following:
        i. ONE of the following:
            a) Height more than 2 standard deviations (SD) below the mean for age and sex OR
            b) Height more than 1.5 SD below the midparental height OR
            c) A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over 2 years AND
        ii. Failure of at least 2 GH stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab) OR
    f. Patient has a diagnosis of small for gestational age* AND ALL of the following:
        i. Patient is at least 2 years of age AND
        ii. Documented birth weight and/or length that is 2 or more SD below the mean for gestational age AND
        iii. At 24 months of age, the patient fails to manifest catch-up growth evidenced by a height that remains 2 or more SD below the mean for age and sex AND
2. Patient's diagnosis is indicated in the preferred GH agent AND ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

NOTE:
*Use of the preferred agent [Omnitrope] is required

NO prerequisites are required for the diagnosis of Noonan Syndrome

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

For Children – Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Growth Hormone Deficiency (GHD), Short Stature OR
    b. Noonan Syndrome OR
    c. Panhypopituitarism OR
    d. Small for Gestational Age OR
    e. Turner Syndrome OR
    f. Prader-Willi Syndrome AND
3. ALL of the following:
    a. Patient does NOT have closed epiphyses AND
    b. Patient is being monitored for adverse effects of therapy with the requested agent AND
    c. Patient's height has increased or height velocity has improved since initiation or last approval of the requested agent

For Adults – Criteria for initial approval require BOTH of the following:

1. ONE of the following:
    a. Patient has a diagnosis of childhood GHD with genetic or organic origin AND ONE of the following:
        i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR
        ii. Failure of at least one growth hormone (GH) stimulation test as an adult (e.g., peak GH value of 5 mcg/L or lower after stimulation, or otherwise considered abnormal as determined by testing lab) OR
    b. Patient has a diagnosis of acquired adult GHD secondary to structural lesions or trauma AND ONE of the following:
        i. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
            a) Deficiencies in 3 or more pituitary axes AND
            b) Low IGF-1 level without GH replacement therapy OR
        ii. Patient has failed at least one growth hormone (GH) stimulation test as an adult OR
    c. Patient has a diagnosis of idiopathic GHD (adult or childhood onset) AND the patient has failed at least two GH stimulation tests as an adult AND
2. ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

For Adults – Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Childhood growth hormone deficiency (GHD) with genetic or organic origin OR
    b. Acquired adult GHD secondary to structural lesions or trauma OR
    c. Idiopathic GHD (adult or childhood onset) AND
3. Patient is being monitored for adverse effects of therapy with the requested agent AND
4. Patient's IGF-1 level has been evaluated to confirm the appropriateness of the current dose AND
5. Patient has had clinical benefit with the requested agent (i.e., body composition, hip-to-waist ratio, cardiovascular health, bone mineral density, serum cholesterol, physical strength, or quality of life)

Prior Authorization Group Description:
Growth Hormone PA – Nutropin
Drug Name(s)
Nutropin Aq Nuspin 10
Nutropin Aq Nuspin 20
Nutropin Aq Nuspin 5
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
For Children – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of Turner Syndrome* OR
    b. Patient has a diagnosis of chronic renal insufficiency AND BOTH of the following:
        i. Height velocity (HV) is greater than or equal to 1.88 standard deviations (SD) below the mean or less than the third percentile for age and sex AND
        ii. Other etiologies for growth impairment have been addressed OR
    c. Patient has a diagnosis of panhypopituitarism* AND BOTH of the following:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum insulin-like growth factor-1 levels are below the age and sex-appropriate reference range when off GH therapy OR
    d. Patient has a diagnosis of growth hormone deficiency (GHD)* or short stature* AND BOTH of the following:
        i. ONE of the following:
            a) Height more than 2 SD below the mean for age and sex OR
            b) Height more than 1.5 SD below the midparental height OR
            c) A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over 2 years AND
        ii. Failure of at least 2 GH stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab) AND
2. Patient's diagnosis is indicated in the preferred GH agent AND ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

NOTE:
*Use of the preferred agent [Omnitrope] is required
NO prerequisites are required for the diagnosis of chronic renal insufficiency
Age Restriction:
Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months
Other Criteria:
For Children – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Growth Hormone Deficiency, Short Stature OR
    b. Chronic renal insufficiency OR
    c. Panhypopituitarism OR
    d. Turner Syndrome AND
3. ALL of the following:
    a. Patient does NOT have closed epiphyses AND
    b. Patient is being monitored for adverse effects of therapy with the requested agent AND
    c. Patient's height has increased or height velocity has improved since initiation or last approval of the requested agent

For Adults – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of childhood growth hormone deficiency (GHD) with genetic or organic origin AND ONE of the following:
        i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR
        ii. Failure of at least one growth hormone (GH) stimulation test as an adult (e.g., peak GH value of 5 mcg/L or lower after stimulation, or otherwise considered abnormal as determined by testing lab) OR
    b. Patient has a diagnosis of acquired adult GHD secondary to structural lesions or trauma AND ONE of the following:
        i. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
            a) Deficiencies in 3 or more pituitary axes AND
            b) Low IGF-1 level without GH replacement therapy OR
        ii. Patient has failed at least one growth hormone (GH) stimulation test as an adult OR
    c. Patient has a diagnosis of idiopathic GHD (adult or childhood onset) AND the patient has failed at least two growth hormone (GH) stimulation tests as an adult AND
2. ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

For Adults – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Childhood growth hormone deficiency (GHD) with genetic or organic origin OR
    b. Acquired adult GHD secondary to structural lesions or trauma OR

c. Idiopathic GHD (adult or childhood onset) AND

3. Patient is being monitored for adverse effects of therapy with the requested agent AND
4. Patient's IGF-1 level has been evaluated to confirm the appropriateness of the current dose AND
5. Patient has had clinical benefit with the requested agent (i.e., body composition, hip-to-waist ratio, cardiovascular health, bone mineral density, serum cholesterol, physical strength, or quality of life)

Prior Authorization Group Description:
Growth Hormone PA – Omnitrope
Drug Name(s)
Omnitrope
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
For Children – Criteria for initial approval require the following:
1. ONE of the following:
    a. Patient has a diagnosis of Turner Syndrome OR
    b. Patient has a diagnosis of Prader-Willi Syndrome OR
    c. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR
    d. Patient has a diagnosis of growth hormone deficiency (GHD) or short stature AND BOTH of the following:
        i. Patient has ONE of the following:
            a) Height more than 2 standard deviations (SD) below the mean for age and sex OR
            b) Height more than 1.5 SD below the midparental height OR
            c) A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over two years AND
        ii. Failure of at least 2 growth hormone (GH) stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab) OR
    e. Patient has a diagnosis of small for gestational age (SGA) AND ALL of the following:
        i. Patient is at least 2 years of age AND
        ii. Documented birth weight and/or length that is 2 or more SD below the mean for gestational age AND
        iii. At 24 months of age, the patient fails to manifest catch-up growth evidenced by a height that remains 2 or more SD below the mean for age and sex
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
For Children – Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the preferred agent through the plan's Prior Authorization criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Growth Hormone Deficiency, Short Stature OR
    b. Panhypopituitarism OR
    c. Prader-Willi Syndrome OR
    d. Small for Gestational Age (SGA) OR
    e. Turner Syndrome AND
3. ALL of the following:
    a. Patient does NOT have closed epiphyses AND
    b. Patient is being monitored for adverse effects of therapy with the requested agent AND
    c. Patient's height has increased or height velocity has improved since initiation or last approval of the requested agent

For Adults – Criteria for initial approval require the following:
1. Patient has been diagnosed with ONE of the following:
    a. Childhood growth hormone deficiency (GHD) with genetic or organic origin AND ONE of the following:
        i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR
        ii. Failure of at least one growth hormone (GH) stimulation test as an adult (e.g., peak GH value of 5 mcg/L or lower after stimulation, or otherwise considered abnormal as determined by testing lab) OR
    b. Acquired adult GHD secondary to structural lesions or trauma AND ONE of the following:
        i. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
            a) Deficiencies in 3 or more pituitary axes AND
            b) Low IGF-1 level without GH replacement therapy OR
        ii. Patient has failed at least one growth hormone (GH) stimulation test as an adult OR
    c. Idiopathic GHD (adult or childhood onset) AND the patient has failed at least two growth hormone (GH) stimulation tests as an adult

For Adults – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the preferred agent through the plan's Prior Authorization criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Childhood growth hormone deficiency (GHD) with genetic or organic origin OR
    b. Acquired adult GHD secondary to structural lesions or trauma OR
    c. Idiopathic GHD (adult or childhood onset) AND
3. Patient is being monitored for adverse effects of therapy with the requested agent AND
4. Patient's IGF-1 level has been evaluated to confirm the appropriateness of the current dose AND
5. Patient has had clinical benefit with the requested agent (i.e., body composition, hip-to-waist ratio, cardiovascular health, bone mineral density, serum cholesterol, physical strength, or quality of life)

Prior Authorization Group Description:
Growth Hormone PA – Saizen
Drug Name(s)
Saizen
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
For Children – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR
    b. Patient has a diagnosis of growth hormone deficiency (GHD) or short stature AND BOTH of the following:
        i. ONE of the following:
            a) Height more than 2 standard deviations (SD) below the mean for age and sex OR
            b) Height more than 1.5 SD below the midparental height OR
            c) A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over two years AND
        ii. Failure of at least 2 GH stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab) AND
2. ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
For Children – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Growth Hormone Deficiency, Short Stature OR
    b. Panhypopituitarism AND
3. ALL of the following:

a. Patient does NOT have closed epiphyses AND
b. Patient is being monitored for adverse effects of therapy with the requested agent AND
c. Patient's height has increased or height velocity has improved since initiation or last approval of the requested agent

For Adults – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
a. Patient has a diagnosis of childhood growth hormone deficiency (GHD) with genetic or organic origin AND ONE of the following:
i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR
ii. Failure of at least one growth hormone (GH) stimulation test as an adult (e.g., peak GH value of 5 mcg/L or lower after stimulation, or otherwise considered abnormal as determined by testing lab) OR
b. Patient has a diagnosis of acquired adult GHD secondary to structural lesions or trauma AND ONE of the following:
i. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
a) Deficiencies in 3 or more pituitary axes AND
b) Low IGF-1 level without GH replacement therapy OR
ii. Patient has failed at least one growth hormone (GH) stimulation test as an adult OR
c. Patient has a diagnosis of idiopathic GHD (adult or childhood onset) AND the patient has failed at least two growth hormone (GH) stimulation tests as an adult AND
2. ONE of the following:
a. Patient has tried and failed the preferred agent [Omnitrope] OR
b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

For Adults – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has been diagnosed with ONE of the following:
a. Childhood growth hormone deficiency (GHD) with genetic or organic origin OR
b. Acquired adult GHD secondary to structural lesions or trauma OR
c. Idiopathic GHD (adult or childhood onset) AND
3. Patient is being monitored for adverse effects of therapy with the requested agent AND
4. Patient's IGF-1 level has been evaluated to confirm the appropriateness of the current dose AND
5. Patient has had clinical benefit with the requested agent (i.e., body composition, hip-to-waist ratio, cardiovascular health, bone mineral density, serum cholesterol, physical strength, or quality of life)

Prior Authorization Group Description:
Growth Hormone PA – Serostim
Drug Name(s)
Serostim
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. The requested agent is for the treatment of an HIV patient with wasting or cachexia AND
2. BOTH of the following:
    a. The requested agent will be used in combination with antiretroviral therapy AND
    b. ONE of the following:
        i. Patient has had an unintentional weight loss of 10% or more of body weight over 12 months OR
        ii. Patient has had an unintentional weight loss of greater than 7.5% over 6 months OR
        iii. Patient has a mid-upper arm circumference less than 10th percentile OR
        iv. Patient has a body cell mass (BCM) loss of 5% or more over 6 months OR
        v. Patient's sex is male, has a BCM less than 35% AND a BMI of less than 27 kg/m2 OR
        vi. Patient's sex is female, has a BCM less than 23% AND a BMI of less than 27 kg/m2

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. The requested agent is for the treatment of an HIV patient with wasting or cachexia AND
3. BOTH of the following:
    a. The requested agent will be used in combination with antiretroviral therapy AND
    b. Patient has had clinical benefit with the requested agent (e.g., weight increase or weight stabilization)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 weeks
Other Criteria:

Prior Authorization Group Description:
Growth Hormone PA – Skytrofa
Drug Name(s)
Skytrofa
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
For Children – Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of growth hormone deficiency (GHD), short stature, or growth failure due to inadequate secretion of endogenous growth hormone AND BOTH of the following:
    a. ONE of the following:
        i. Height more than 2 standard deviations (SD) below the mean for age and sex OR
        ii. Height more than 1.5 SD below the midparental height OR
        iii. A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
        iv. Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over two years AND
    b. Failure of at least 2 GH stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab) AND
2. ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

For Children – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of growth hormone deficiency (GHD), short stature, or growth failure due to inadequate secretion of endogenous growth hormone AND
3. ALL of the following:
    a. Patient does NOT have closed epiphyses AND
    b. Patient is being monitored for adverse effects of therapy with the requested agent AND
    c. Patient's height has increased or height velocity has improved since initiation or last approval of the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Growth Hormone PA – Sogroya
Drug Name(s)
Sogroya
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
For Children – Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of growth hormone deficiency (GHD), short stature, or growth failure due to inadequate secretion of endogenous growth hormone AND BOTH of the following:
    a. ONE of the following:
        i. Height more than 2 standard deviations (SD) below the mean for age and sex OR
        ii. Height more than 1.5 SD below the midparental height OR
        iii. A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
        iv. Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over two years AND
    b. Failure of at least 2 GH stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab) AND
2. ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

For Children – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of growth hormone deficiency (GHD), short stature, or growth failure due to inadequate secretion of endogenous growth hormone AND
3. ALL of the following:
    a. Patient does NOT have closed epiphyses AND
    b. Patient is being monitored for adverse effects of therapy with the requested agent AND
    c. Patient's height has increased or height velocity has improved since initiation or last approval of the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
For Adults – Criteria for initial approval require BOTH of the following:
1. ONE of the following:

a. Patient has a diagnosis of childhood growth hormone deficiency (GHD) with genetic or organic origin AND ONE of the following:
    i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR
    ii. Failure of at least one growth hormone (GH) stimulation test as an adult (e.g., peak GH value of 5 mcg/L or lower after stimulation, or otherwise considered abnormal as determined by testing lab) OR

b. Patient has a diagnosis of acquired adult GHD secondary to structural lesions or trauma AND ONE of the following:
    i. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
        a) Deficiencies in 3 or more pituitary axes AND
        b) Low IGF-1 level without GH replacement therapy OR
    ii. Patient has failed at least one growth hormone (GH) stimulation test as an adult OR

c. Patient has a diagnosis of idiopathic GHD (adult or childhood onset) AND the patient has failed at least two GH stimulation tests as an adult AND

2. ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

For Adults – Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Childhood growth hormone deficiency (GHD) with genetic or organic origin OR
    b. Acquired adult GHD secondary to structural lesions or trauma OR
    c. Idiopathic GHD (adult or childhood onset) AND
3. Patient is being monitored for adverse effects of therapy with the requested agent AND
4. Patient's IGF-1 level has been evaluated to confirm the appropriateness of the current dose AND
5. Patient has had clinical benefit with the requested agent (i.e., body composition, hip-to-waist ratio, cardiovascular health, bone mineral density, serum cholesterol, physical strength, or quality of life)

Prior Authorization Group Description:
Growth Hormone PA – Zomacton
Drug Name(s)
Zomacton
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
For Children – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of Turner Syndrome* OR
    b. Patient has a diagnosis of SHOX gene deficiency OR
    c. Patient has a diagnosis of panhypopituitarism* AND BOTH of the following:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR
    d. Patient has a diagnosis of growth hormone deficiency (GHD)* or short stature* AND BOTH of the following:
        i. ONE of the following:
            a) Height more than 2 standard deviation (SD) below the mean for age and sex OR
            b) Height more than 1.5 SD below the midparental height OR
            c) A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over 2 years AND
        ii. Failure of at least 2 GH stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab) OR
    e. Patient has a diagnosis of small for gestational age* AND ALL of the following:
        i. Patient is at least 2 years of age AND
        ii. Documented birth weight and/or length that is 2 or more SD below the mean for gestational age AND
        iii. At 24 months of age, the patient fails to manifest catch-up growth evidenced by a height that remains 2 or more SD below the mean for age and sex AND
2. Patient's diagnosis is indicated in the preferred GH agent AND ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

NOTE:
*Use of the preferred agent [Omnitrope] is required
NO prerequisites are required for the diagnosis of SHOX gene deficiency

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
For Children – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Growth Hormone Deficiency, Short Stature OR
    b. Panhypopituitarism OR
    c. Small for Gestational Age OR
    d. SHOX gene deficiency OR
    e. Turner Syndrome AND
3. ALL of the following:
    a. Patient does NOT have closed epiphyses AND
    b. Patient is being monitored for adverse effects of therapy with the requested agent AND
    c. Patient's height has increased or height velocity has improved since initiation or last approval of the requested agent

For Adults – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of childhood growth hormone deficiency (GHD) with genetic or organic origin AND ONE of the following:
        i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR
        ii. Failure of at least one growth hormone (GH) stimulation test as an adult (e.g., peak GH value of 5 mcg/L or lower after stimulation, or otherwise considered abnormal as determined by testing lab) OR
    b. Patient has a diagnosis of acquired adult GHD secondary to structural lesions or trauma AND ONE of the following:
        i. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
            a) Deficiencies in 3 or more pituitary axes AND
            b) Low IGF-1 level without GH replacement therapy OR
        ii. Patient has failed at least one growth hormone (GH) stimulation test as an adult OR
    c. Patient has a diagnosis of idiopathic GHD (adult or childhood onset) AND the patient has failed at least two GH stimulation tests as an adult AND
2. ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

For Adults – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND

2. Patient has been diagnosed with ONE of the following:
    a. Childhood growth hormone deficiency (GHD) with genetic or organic origin OR
    b. Acquired adult GHD secondary to structural lesions or trauma OR
    c. Idiopathic GHD (adult or childhood onset) AND
3. Patient is being monitored for adverse effects of therapy with the requested agent AND
4. Patient's IGF-1 level has been evaluated to confirm the appropriateness of the current dose AND
5. Patient has had clinical benefit with the requested agent (i.e., body composition, hip-to-waist ratio, cardiovascular health, bone mineral density, serum cholesterol, physical strength, or quality of life)

Prior Authorization Group Description:
Growth Hormone PA – Zorbtive
Drug Name(s)
Zorbtive
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of short bowel syndrome (SBS) AND
2. Patient is receiving specialized nutritional support

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of SBS AND
3. Patient has had clinical benefit with the requested agent (e.g., decrease in enteral or parenteral nutrition requirements)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 4 weeks
Other Criteria:

Prior Authorization Group Description:
HAE PA – Berinert
Drug Name(s)
Berinert
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed via two confirmatory tests of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type I)]: decreased quantities of C4 and C1-INH (antigenic and functional level) OR
    b. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type II)]: decreased quantities of C4 and C1-INH function (C1-INH protein level may be normal) OR
    c. Hereditary angioedema (HAE) with normal C1INH [HAE-nI-C1INH (Type III)]: Normal levels of C4 and C1-INH [antigenic and functional level (at baseline and during an attack)] AND ONE of the following:
        i. BOTH of the following:
            1. Family history of angioedema AND
            2. ALL other causes of angioedema have been ruled out OR
        ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, plasminogen (PLG) mutation, kininogen1 mutation, heparan sulfate 3-O-sulfotransferase 6 gene mutation, or myoferlin gene mutation that is associated with the disease AND
2. Medications known to cause angioedema (e.g., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. The requested agent will be used to treat acute HAE attacks AND
4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of hereditary angioedema (HAE) AND
3. The requested agent will be used to treat acute HAE attacks AND
4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks AND

5. Patient has had a decrease in the frequency or severity of acute attacks or stabilization of disease from use of the requested agent

Prior Authorization Group Description:
HAE PA – Cinryze
Drug Name(s)
Cinryze
Indications:
All FDA-Approved Indications, Some Medically-Accepted Indications.
Off-Label Uses:
Acute HAE attacks
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed via two confirmatory tests of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type I)]: decreased quantities of C4 and C1-INH (antigenic and functional level) OR
    b. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type II)]: decreased quantities of C4 and C1-INH function (C1-INH protein level may be normal) OR
    c. Hereditary angioedema (HAE) with normal C1INH [HAE-nI-C1INH (Type III)]: Normal levels of C4 and C1-INH [antigenic and functional level (at baseline and during an attack)] AND ONE of the following:
        i. BOTH of the following:
            1. Family history of angioedema AND
            2. ALL other causes of angioedema have been ruled out OR
        ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, plasminogen (PLG) mutation, kininogen1 mutation, heparan sulfate 3-O-sulfotransferase 6 gene mutation, or myoferlin gene mutation that is associated with the disease AND
2. Medications known to cause angioedema (e.g., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. ONE of the following:
    a. The requested agent will be used to treat acute HAE attacks AND the patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks OR
    b. The requested agent will be used for prophylaxis against HAE attacks AND the patient will NOT be using the requested agent in combination with another HAE agent indicated for prophylaxis against HAE attacks
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria
AND
2. Patient has a diagnosis of hereditary angioedema (HAE) AND ONE of the following:
    a. The requested agent will be used to treat acute HAE attacks AND the patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks OR
    b. The requested agent will be used for prophylaxis against HAE attacks AND the patient will NOT be using the requested agent in combination with another HAE agent indicated for prophylaxis against HAE attacks AND
3. Patient has had a decrease in the frequency or severity of acute attacks or has had stabilization of disease from use of the requested agent

Prior Authorization Group Description:
HAE PA – Haegarda
Drug Name(s)
Haegarda
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed via two confirmatory tests of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type I)]: decreased quantities of C4 and C1-INH (antigenic and functional level) OR
    b. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type II)]: decreased quantities of C4 and C1-INH function (C1-INH protein level may be normal) OR
    c. Hereditary angioedema (HAE) with normal C1INH [HAE-nI-C1INH (Type III)]: Normal levels of C4 and C1-INH [antigenic and functional level (at baseline and during an attack)] AND ONE of the following:
        i. BOTH of the following:
            1. Family history of angioedema AND
            2. ALL other causes of angioedema have been ruled out OR
        ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, plasminogen (PLG) mutation, kininogen1 mutation, heparan sulfate 3-O-sulfotransferase 6 gene mutation, or myoferlin gene mutation that is associated with the disease AND
2. Medications known to cause angioedema (e.g., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. The requested agent will be used for prophylaxis against HAE attacks AND
4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for prophylaxis against HAE attacks
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of hereditary angioedema (HAE) AND
3. The requested agent is being used for prophylaxis against HAE attacks AND
4. Patient has had a decrease in the frequency or severity of acute attacks or has had stabilization of disease from use of the requested agent AND

5. Patient will NOT be using the requested agent in combination with another HAE agent indicated for prophylaxis against HAE attacks

Prior Authorization Group Description:
HAE PA – Icatibant
Drug Name(s)
Firazyr
Icatibant Acetate
Sajazir
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed via two confirmatory tests of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type I)]: decreased quantities of C4 and C1-INH (antigenic and functional level) OR
    b. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type II)]: decreased quantities of C4 and C1-INH function (C1-INH protein level may be normal) OR
    c. Hereditary angioedema (HAE) with normal C1INH [HAE-nI-C1INH (Type III)]: Normal levels of C4 and C1-INH [antigenic and functional level (at baseline and during an attack)] AND ONE of the following:
        i. BOTH of the following:
            1. Family history of angioedema AND
            2. ALL other causes of angioedema have been ruled out OR
        ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, plasminogen (PLG) mutation, kininogen1 mutation, heparan sulfate 3-O-sulfotransferase 6 gene mutation, or myoferlin gene mutation that is associated with the disease AND
2. Medications known to cause angioedema (e.g., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. The requested agent will be used to treat acute HAE attacks AND
4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of hereditary angioedema (HAE) AND
3. The requested agent will be used to treat acute HAE attacks AND

4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks AND
5. Patient has had a decrease in the frequency or severity of acute attacks or stabilization of disease from use of the requested agent

Prior Authorization Group Description:
HAE PA – Kalbitor
Drug Name(s)
Kalbitor
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed via two confirmatory tests of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type I)]: decreased quantities of C4 and C1-INH (antigenic and functional level) OR
    b. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type II)]: decreased quantities of C4 and C1-INH function (C1-INH protein level may be normal) OR
    c. Hereditary angioedema (HAE) with normal C1INH [HAE-nI-C1INH (Type III)]: Normal levels of C4 and C1-INH [antigenic and functional level (at baseline and during an attack)] AND ONE of the following:
        i. BOTH of the following:
            1. Family history of angioedema AND
            2. ALL other causes of angioedema have been ruled out OR
        ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, plasminogen (PLG) mutation, kininogen1 mutation, heparan sulfate 3-O-sulfotransferase 6 gene mutation, or myoferlin gene mutation that is associated with the disease AND
2. Medications known to cause angioedema (e.g., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. The requested agent will be used to treat acute HAE attacks AND
4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of hereditary angioedema (HAE) AND
3. The requested agent will be used to treat acute HAE attacks AND
4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks AND

5. Patient has had a decrease in the frequency or severity of acute attacks or stabilization of disease from use of the requested agent

Prior Authorization Group Description:
HAE PA – Orladeyo
Drug Name(s)
Orladeyo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed via two confirmatory tests of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type I)]: decreased quantities of C4 and C1-INH (antigenic and functional level) OR
    b. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type II)]: decreased quantities of C4 and C1-INH function (C1-INH protein level may be normal) OR
    c. Hereditary angioedema (HAE) with normal C1INH [HAE-nI-C1INH (Type III)]: Normal levels of C4 and C1-INH [antigenic and functional level (at baseline and during an attack)] AND ONE of the following:
        i. BOTH of the following:
            1. Family history of angioedema AND
            2. ALL other causes of angioedema have been ruled out OR
        ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, plasminogen (PLG) mutation, kininogen1 mutation, heparan sulfate 3-O-sulfotransferase 6 gene mutation, or myoferlin gene mutation that is associated with the disease AND
2. Medications known to cause angioedema (e.g., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. The requested agent will be used for prophylaxis against HAE attacks AND
4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for prophylaxis against HAE attacks
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of hereditary angioedema (HAE) AND
3. The requested agent is being used for prophylaxis against HAE attacks AND
4. Patient has had a decrease in the frequency or severity of acute attacks or has had stabilization of disease from use of the requested agent AND

5. Patient will NOT be using the requested agent in combination with another HAE agent indicated for prophylaxis against HAE attacks

Prior Authorization Group Description:
HAE PA – Ruconest
Drug Name(s)
Ruconest
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed via two confirmatory tests of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type I)]: decreased quantities of C4 and C1-INH (antigenic and functional level) OR
    b. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type II)]: decreased quantities of C4 and C1-INH function (C1-INH protein level may be normal) OR
    c. Hereditary angioedema (HAE) with normal C1INH [HAE-nI-C1INH (Type III)]: Normal levels of C4 and C1-INH [antigenic and functional level (at baseline and during an attack)] AND ONE of the following:
        i. BOTH of the following:
            1. Family history of angioedema AND
            2. ALL other causes of angioedema have been ruled out OR
        ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, plasminogen (PLG) mutation, kininogen1 mutation, heparan sulfate 3-O-sulfotransferase 6 gene mutation, or myoferlin gene mutation that is associated with the disease AND
2. Medications known to cause angioedema (e.g., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. The requested agent will be used to treat acute HAE attacks AND
4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of hereditary angioedema (HAE) AND
3. The requested agent will be used to treat acute HAE attacks AND
4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks AND

5. Patient has had a decrease in the frequency or severity of acute attacks or stabilization of disease from use of the requested agent

Prior Authorization Group Description:
HAE PA – Takhzyro
Drug Name(s)
Takhzyro
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed via two confirmatory tests of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type I)]: decreased quantities of C4 and C1-INH (antigenic and functional level) OR
    b. Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type II)]: decreased quantities of C4 and C1-INH function (C1-INH protein level may be normal) OR
    c. Hereditary angioedema (HAE) with normal C1INH [HAE-nI-C1INH (Type III)]: Normal levels of C4 and C1-INH [antigenic and functional level (at baseline and during an attack)] AND ONE of the following:
        i. BOTH of the following:
            1. Family history of angioedema AND
            2. ALL other causes of angioedema have been ruled out OR
        ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, plasminogen (PLG) mutation, kininogen1 mutation, heparan sulfate 3-O-sulfotransferase 6 gene mutation, or myoferlin gene mutation that is associated with the disease AND
2. Medications known to cause angioedema (e.g., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. The requested agent will be used for prophylaxis against HAE attacks AND
4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for prophylaxis against HAE attacks
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of hereditary angioedema (HAE) AND
3. The requested agent is being used for prophylaxis against HAE attacks AND
4. Patient has had a decrease in the frequency or severity of acute attacks or has had stabilization of disease from use of the requested agent AND

5. Patient will NOT be using the requested agent in combination with another HAE agent indicated for prophylaxis against HAE attacks

Prior Authorization Group Description:
Harvoni PA
Drug Name(s)
Harvoni
Ledipasvir/Sofosbuvir
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The requested dose is within FDA labeled dosing or supported in AASLD/IDSA dosing for the requested indication AND
5. ONE of the following:
    A. The requested agent is the preferred agent: Harvoni OR
    B. The requested agent is the non-preferred agent: ledipasvir/sofosbuvir AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. Patient has an FDA labeled contraindication or hypersensitivity to TWO preferred agents: Epclusa and Harvoni for supported genotypes OR
        iv. Prescriber has provided information based on FDA approved labeling or AASLD/IDSA guidelines supporting the use of the non-preferred agent for the patient's diagnosis and genotype over TWO preferred agents: Epclusa and Harvoni for supported genotypes
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported
Other Criteria:

Prior Authorization Group Description:
Hetlioz LQ Suspension PA
Drug Name(s)
Hetlioz Lq
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of Smith-Magenis Syndrome (SMS) confirmed by the presence of ONE of the following genetic mutations:
    A. A heterozygous deletion of 17p11.2 OR
    B. A heterozygous pathogenic variant involving RAI1 AND
2. The requested agent is being used to treat nighttime sleep disturbances associated with SMS
Age Restriction:
Patient is 3 to 15 years of age
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist, sleep specialist, psychiatrist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
High Risk Medication PA - All Starts
Drug Name(s)
Ascomp/Codeine
Benztropine Mesylate
Bonjesta
Butalbital/Acetaminophen/Caffeine/Codeine
Butalbital/Aspirin/Caffeine/Codeine
Carbinoxamine Maleate
Clemastine Fumarate
Cyproheptadine Hydrochloride
Diclegis
Dicyclomine Hydrochloride
Diphenoxylate Hydrochloride/Atropine Sulfate
Diphenoxylate/Atropine
Disopyramide Phosphate
Doxylamine Succinate/Pyridoxine Hydrochloride
Fioricet/Codeine
Hydroxyzine Hydrochloride
Hydroxyzine Pamoate
Lomotil
Methscopolamine Bromide
Norpace
Norpace Cr
Promethazine Hcl Plain
Promethazine Hydrochloride
Promethazine Vc
Promethazine/Phenylephrine
Promethegan
Ryclora
Ryvent
Scopolamine
Transderm-Scop
Trihexyphenidyl Hydrochloride
Vistaril
Indications:
All Medically-Accepted Indications.

Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND
2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND
3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
HoFH PA – Juxtapid
Drug Name(s)
Juxtapid
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) AND
2. ONE of the following:
    A. Genetic confirmation of two mutant alleles at the LDLR, Apo-B, PCSK9, or LDLRAP1 gene OR
    B. History of untreated LDL-C greater than 500 mg/dL (greater than 13 mmol/L) or treated LDL-C 300 mg/dL or greater (7.76 mmol/L or greater) OR
    C. Patient has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma) AND
3. ONE of the following:
    A. Patient is currently being treated with a maximally tolerated statin-containing lipid-lowering regimen in the last 90 days (i.e., rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe) OR
    B. Patient has an intolerance or hypersensitivity to a maximally tolerated statin-containing lipid-lowering regimen (i.e., rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe) OR
    C. Patient has an FDA labeled contraindication to a maximally tolerated statin-containing lipid-lowering regimen (i.e., rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe)
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist, endocrinologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) AND
3. Patient has had clinical benefit with the requested agent AND
4. ONE of the following:
    A. Patient is currently being treated with a maximally tolerated statin-containing lipid-lowering regimen in the last 90 days (i.e., rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe) OR

B. Patient has an intolerance or hypersensitivity to a maximally tolerated statin-containing lipid-lowering regimen (i.e., rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe) OR
C. Patient has an FDA labeled contraindication to a maximally tolerated statin-containing lipid-lowering regimen (i.e., rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe)

Prior Authorization Group Description:
Horizant PA
Drug Name(s)
Horizant
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. Patient has a diagnosis of Postherpetic Neuralgia (PHN) AND
        ii. ONE of the following:
            1. Patient has tried and had an inadequate response to immediate-release gabapentin OR
            2. Patient has an intolerance or hypersensitivity to immediate-release gabapentin OR
            3. Patient has an FDA labeled contraindication to immediate-release gabapentin that is not expected to occur with the requested agent OR
    B. BOTH of the following:
        i. Patient has a diagnosis of moderate-to-severe primary Restless Legs Syndrome (RLS) AND
        ii. BOTH of the following:
            1. ONE of the following:
                a. Patient has tried and had an inadequate response to immediate-release ropinirole OR
                b. Patient has an intolerance or hypersensitivity to immediate-release ropinirole OR
                c. Patient has an FDA labeled contraindication to immediate-release ropinirole AND
            2. ONE of the following:
                a. Patient has tried and had an inadequate response to immediate-release pramipexole OR
                b. Patient has an intolerance or hypersensitivity to immediate-release pramipexole OR
                c. Patient has an FDA labeled contraindication to immediate-release pramipexole

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of Postherpetic Neuralgia (PHN) OR

B. Patient has a diagnosis of moderate-to-severe primary Restless Legs Syndrome (RLS) AND

3. Patient has had clinical benefit with the requested agent

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Hyftor PA
Drug Name(s)
Hyftor
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of facial angiofibroma associated with tuberous sclerosis AND
2. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 weeks
Other Criteria:

Prior Authorization Group Description:
Ilaris PA
Drug Name(s)
Ilaris
Indications:
All FDA-Approved Indications, Some Medically-Accepted Indications.
Off-Label Uses:
Acute gouty arthritis
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of:
1. ONE of the following:
    A. Patient (pt) has been diagnosed with Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) OR
    B. Pt has been diagnosed with Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD) OR
    C. Pt has been diagnosed with Familial Mediterranean Fever (FMF) AND ONE of the following:
        i. Pt has tried and had an inadequate response to colchicine OR
        ii. Pt has an intolerance or hypersensitivity to colchicine OR
        iii. Pt has an FDA labeled contraindication to colchicine OR
    D. Pt has been diagnosed with Cryopyrin-Associated Periodic Syndrome (CAPS) including Familial Cold Auto-inflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS) OR
    E. Pt has been diagnosed with active Systemic Juvenile Idiopathic Arthritis (SJIA) AND BOTH of the following:
        i. Pt has documented active systemic features (e.g., ongoing fever, evanescent erythematous rash, generalized lymphadenopathy, 1 or more joints with active arthritis, hepatomegaly, splenomegaly, serositis) AND
        ii. ONE of the following:
            a. Pt has tried and had an inadequate response to at least ONE prerequisite agent (e.g., glucocorticosteroids, prescription oral NSAIDs, methotrexate, leflunomide) OR
            b. Pt has an intolerance or hypersensitivity to at least ONE prerequisite agent OR
            c. Pt has an FDA labeled contraindication to at least ONE prerequisite agent OR
    F. Pt has a diagnosis of adult onset Still's disease OR
    G. Pt has been diagnosed with acute gouty arthritis AND ONE of the following:
        i. Pt has tried and had an inadequate response to at least TWO conventional first-line agents (e.g., prescription oral NSAIDs, colchicine, systemic corticosteroids) OR
        ii. Pt has an intolerance or hypersensitivity to at least TWO conventional first-line agents OR
        iii. Pt has an FDA labeled contraindication to at least TWO conventional first-line agents AND
2. Pt will NOT be using the requested agent in combination with another biologic agent
Age Restriction:

For diagnosis of CAPS including FCAS or MWS, patient is 4 years of age or over

For diagnosis of SJIA, patient is 2 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Imiquimod PA
Drug Name(s)
Imiquimod
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has ONE of the following diagnoses:
    A. Actinic keratosis OR
    B. Superficial basal cell carcinoma OR
    C. External genital and/or perianal warts/condyloma acuminata OR
    D. Squamous cell carcinoma OR
    E. Basal cell carcinoma OR
    F. Another indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
4 months for Actinic keratosis, other diagnoses - see Other Criteria
Other Criteria:
2 months for Superficial basal cell carcinoma, Squamous cell carcinoma, or Basal cell carcinoma

4 months for External genital and/or perianal warts/condyloma acuminata

12 months for All other diagnoses

Prior Authorization Group Description:
Inbrija PA
Drug Name(s)
Inbrija
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. The requested agent will be used for intermittent treatment of OFF episodes in patients with Parkinson's disease AND
2. Patient is receiving concurrent therapy with carbidopa/levodopa AND
3. Patient will NOT be using a nonselective monoamine oxidase (MAO) inhibitor (e.g., phenelzine, tranylcypromine) in combination with, or within 2 weeks of, the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Ingrezza PA
Drug Name(s)
Ingrezza
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of chorea associated with Huntington's disease AND BOTH of the following:
        i. ONE of the following:
            1. Patient does NOT have a current diagnosis of depression OR
            2. Patient has a current diagnosis of depression and is being treated for depression AND
        ii. ONE of the following:
            1. Patient does NOT have a diagnosis of passive suicidal ideation and/or behavior OR
            2. Patient has a diagnosis of passive suicidal ideation and/or behavior and must NOT be actively suicidal OR
    B. Patient has a diagnosis of tardive dyskinesia AND ONE of the following:
        i. Prescriber has reduced the dose of or discontinued any medications known to cause tardive dyskinesia (i.e., dopamine receptor blocking agents) OR
        ii. Prescriber has provided clinical rationale indicating that a reduced dose or discontinuation of any medications known to cause tardive dyskinesia is not appropriate
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Injectable Oncology PA
Drug Name(s)
Abraxane
Adcetris
Alimta
Aliqopa
Alymsys
Arranon
Avastin
Beleodaq
Besponsa
Blenrep
Blincyto
Bortezomib
Cyramza
Danyelza
Darzalex
Darzalex Faspro
Doxil
Doxorubicin Hydrochloride Liposomal
Empliciti
Enhertu
Erbitux
Faslodex
Folotyn
Fulvestrant
Gazyva
Halaven
Herceptin
Herceptin Hylecta
Herzuma
Infugem
Istodax (Overfill)
Jevtana
Kadcyla
Kanjinti

Kyprolis
Lumoxiti
Margenza
Monjuvi
Mvasi
Mylotarg
Nelarabine
Ogivri
Onivyde
Ontruzant
Padcev
Pemetrexed
Perjeta
Phesgo
Polivy
Portrazza
Poteligeo
Romidepsin
Rybrevant
Sarclisa
Synribo
Trazimera
Trodelvy
Unituxin
Vectibix
Vegzelma
Velcade
Vyxeos
Yondelis
Zaltrap
Zepzelca
Zirabev
Zynlonta

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. The requested agent is FDA labeled or supported by CMS approved compendia as first-line therapy for the requested indication OR
            b. Patient has tried appropriate FDA labeled or CMS approved compendia supported therapy that are indicated as first-line therapy for the requested indication OR
            c. Patient has an intolerance or hypersensitivity to the first-line therapy for the requested indication OR
            d. Patient has an FDA labeled contraindication to the first-line therapy for the requested indication AND
        iii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iv. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines

May also be subject to Part B versus Part D review.
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Intrarosa PA
Drug Name(s)
Intrarosa
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Iron Chelating Agents PA – Exjade
Drug Name(s)
Deferasirox (Exjade)
Exjade
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome AND ONE of the following:
        i. A liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight OR
        ii. A serum ferritin greater than 300 mcg/L OR
        iii. MRI confirmation of iron deposition OR
    B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND
2. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome OR
    B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent for the requested indication
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Iron Chelating Agents PA – Jadenu
Drug Name(s)
Deferasirox (Jadenu)
Jadenu
Jadenu Sprinkle
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome AND ONE of the following:
        i. A liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight OR
        ii. A serum ferritin greater than 300 mcg/L OR
        iii. MRI confirmation of iron deposition OR
    B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND
2. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome OR
    B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent for the requested indication
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Isturisa PA
Drug Name(s)
Isturisa
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Cushing's disease AND
2. ONE of the following:
    A. Patient had an inadequate response to pituitary surgical resection OR
    B. Patient is NOT a candidate for pituitary surgical resection AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to pasireotide OR
    B. Patient has an intolerance or hypersensitivity to pasireotide OR
    C. Patient has an FDA labeled contraindication to pasireotide

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Cushing's disease AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Ivermectin Cream PA
Drug Name(s)
Ivermectin Cream
Soolantra
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Ivermectin Tablet PA
Drug Name(s)
Ivermectin Tablet
Stromectol
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 4 months
Other Criteria:

Prior Authorization Group Description:
Jatenzo PA
Drug Name(s)
Jatenzo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient's sex is male with a diagnosis of primary or secondary (hypogonadotropic) hypogonadism AND
2. ONE of the following:
    A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels:
        i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR
        ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR
    B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels:
        i. Total serum testosterone level that is within OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR
        ii. Free serum testosterone level is within OR below the testing laboratory's normal range AND
3. ONE of the following:
    A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR
    B. Prescriber has provided information in support of therapy with more than one agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Joenja PA
Drug Name(s)
Joenja
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS) AND
2. Patient has a variant in either PIK3CD gene or PIK3R1 gene

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS) AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist, immunologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Jornay PM PA
Drug Name(s)
Jornay Pm
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Jynarque PA
Drug Name(s)
Jynarque
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed by ONE of the following:
    A. Ultrasound OR
    B. MRI or CT scan OR
    C. Genetic testing AND
2. Patient is at risk of rapid disease progression AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD) AND
3. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., nephrologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Kalydeco PA
Drug Name(s)
Kalydeco
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. ONE of the following:
    A. Patient has ONE of the CFTR gene mutations or a mutation in the CFTR gene that is responsive based on in vitro data, as indicated in the FDA label, confirmed by genetic testing OR
    B. Patient has another CFTR gene mutation(s) that is responsive to the requested agent, as indicated in the FDA label, confirmed by genetic testing AND
3. Patient is NOT homozygous for the F508del mutation AND
4. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of cystic fibrosis AND
3. Patient has had improvement or stabilization with the requested agent [e.g., improvement in FEV1 from baseline, increase in weight/BMI, improvement from baseline Cystic Fibrosis Questionnaire-Revised (CFQ-R) Respiratory Domain score, improvements in respiratory symptoms (cough, sputum production, and difficulty breathing), and/or reduced number of pulmonary exacerbations] AND
4. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cystic fibrosis, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Kerendia PA
Drug Name(s)
Kerendia
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Korlym PA
Drug Name(s)
Korlym
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Cushing's syndrome AND
2. ONE of the following:
    A. Patient has type 2 diabetes mellitus OR
    B. Patient has glucose intolerance as defined by a 2-hour glucose tolerance test plasma glucose value of 140-199 mg/dL AND
3. ONE of the following:
    A. Patient has failed surgical resection OR
    B. Patient is NOT a candidate for surgical resection

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Cushing's syndrome AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Leuprolide PA
Drug Name(s)
Eligard
Fensolvi
Leuprolide Acetate
Lupron Depot (1-Month)
Lupron Depot (3-Month)
Lupron Depot (4-Month)
Lupron Depot (6-Month)
Lupron Depot-Ped (1-Month)
Lupron Depot-Ped (3-Month)
Lupron Depot-Ped (6-Month)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. BOTH of the following:
        i. Patient is NOT currently being treated with the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
3. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Lidocaine Topical PA - Lidocaine Gel/Jelly
Drug Name(s)
Glydo
Lidocaine Hcl Gel
Lidocaine Hcl Jelly
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. The requested agent will be used for ONE of the following:
    A. Surface anesthesia and lubrication for urethral procedure OR
    B. Topical treatment for pain of urethritis OR
    C. Surface anesthesia and lubrication for endotracheal intubation (oral and nasal) OR
    D. Another indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Lidocaine Topical PA - Lidocaine Ointment
Drug Name(s)
Lidocaine Ointment
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. The requested agent will be used for ONE of the following:
    A. Anesthesia of accessible mucous membranes of the oropharynx OR
    B. Anesthetic lubricant for intubation OR
    C. Temporary relief of pain associated with minor burns, including sunburn, abrasions of the skin, and insect bites OR
    D. Another indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
        i. Patient has tried and had an inadequate response to a conventional therapy [e.g., gabapentin, pregabalin, oral prescription NSAID (non-steroidal anti-inflammatory drug)] for the requested indication OR
        ii. Patient has an intolerance or hypersensitivity to a conventional therapy OR
        iii. Patient has an FDA labeled contraindication to a conventional therapy
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Lidocaine Topical PA - Lidocaine Patch
Drug Name(s)
Lidocan
Lidocan III
Lidocaine Patch
Lidoderm
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has ONE of the following diagnoses:
    A. Pain associated with postherpetic neuralgia (PHN) OR
    B. Pain associated with diabetic neuropathy OR
    C. Neuropathic pain associated with cancer, or cancer treatment OR
    D. Another diagnosis that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to a conventional therapy [e.g., gabapentin, pregabalin, oral prescription NSAID (non-steroidal anti-inflammatory drug)] for the requested indication OR
    B. Patient has an intolerance or hypersensitivity to a conventional therapy OR
    C. Patient has an FDA labeled contraindication to a conventional therapy
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Lidocaine Topical PA - Lidocaine Solution
Drug Name(s)
Lidocaine Solution
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. The requested agent will be used for ONE of the following:
    A. Topical anesthesia of accessible mucous membranes of the oral and nasal cavities OR
    B. Topical anesthesia of accessible mucous membranes of proximal portions of the digestive tract OR
    C. Another indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Lidocaine Topical PA - Lidocaine/prilocaine Cream
Drug Name(s)
Lidocaine/Prilocaine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. The requested agent will be used for ONE of the following:
    A. Local analgesia on normal intact skin OR
    B. Topical anesthetic for dermal procedures OR
    C. Adjunctive anesthesia prior to local anesthetic infiltration in adult male genital skin OR
    D. Anesthesia for minor procedures on female external genitalia OR
    E. Another indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Lidocaine Topical PA – Pliaglis
Drug Name(s)
Pliaglis
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. The requested agent will be used on intact skin of an adult patient to provide local analgesia for a superficial dermatological procedure (e.g., dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, laser-assisted tattoo removal)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Lidocaine Topical PA – ZTlido
Drug Name(s)
Ztlido
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    A. Pain associated with postherpetic neuralgia (PHN) OR
    B. Neuropathic pain associated with cancer, or cancer treatment OR
    C. Another diagnosis that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to generic lidocaine 5% patch OR
    B. Patient has an intolerance or hypersensitivity to generic lidocaine 5% patch OR
    C. Patient has an FDA labeled contraindication to generic lidocaine 5% patch AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to a conventional therapy [e.g., gabapentin, pregabalin, oral prescription NSAID (non-steroidal anti-inflammatory drug)] for the requested indication OR
    B. Patient has an intolerance or hypersensitivity to a conventional therapy OR
    C. Patient has an FDA labeled contraindication to a conventional therapy

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Linezolid PA
Drug Name(s)
Linezolid
Zyvox
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND ONE of the following:
    a. The requested agent is prescribed by an infectious disease specialist or the prescriber has consulted with an infectious disease specialist on treatment of this patient OR
    b. Patient has a documented infection due to vancomycin-resistant Enterococcus faecium OR
    c. Patient has a diagnosis of pneumonia caused by Staphylococcus aureus or Streptococcus pneumoniae AND ONE of the following:
        i. Patient has a documented infection that is resistant to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole, OR that is resistant to vancomycin OR
        ii. Patient has an intolerance or hypersensitivity to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR
        iii. Patient has an FDA labeled contraindication to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR
        iv. Patient has an intolerance or hypersensitivity to vancomycin OR
        v. Patient has an FDA labeled contraindication to vancomycin OR
    d. Patient has a documented skin and skin structure infection, including diabetic foot infections, caused by Staphylococcus aureus, Streptococcus pyogenes, or Streptococcus agalactiae AND ONE of the following:
        i. Patient has a documented infection that is resistant to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole, OR that is resistant to vancomycin at the site of infection OR
        ii. Patient has an intolerance or hypersensitivity to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR
        iii. Patient has an FDA labeled contraindication to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR

Criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 3 months
Other Criteria:

iv. Patient has an intolerance or hypersensitivity to vancomycin OR
v. Patient has an FDA labeled contraindication to vancomycin AND

2. Patient will NOT be using the requested agent in combination with Sivextro (tedizolid) for the same infection AND

3. The requested dose is within FDA labeled dosing for the requested indication

Prior Authorization Group Description:
Livmarli PA
Drug Name(s)
Livmarli
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of Alagille Syndrome (ALGS) AND
2. The requested agent will be used to treat cholestatic pruritus AND
3. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Lumryz PA
Drug Name(s)
Lumryz Pak
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of narcolepsy with cataplexy OR
    B. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness AND BOTH of the following:
        i. ONE of the following:
            a. Patient has tried and had an inadequate response to modafinil or armodafinil OR
            b. Patient has an intolerance or hypersensitivity to modafinil or armodafinil OR
            c. Patient has an FDA labeled contraindication to modafinil or armodafinil AND
        ii. ONE of the following:
            a. Patient has tried and had an inadequate response to ONE standard stimulant agent (e.g., methylphenidate) OR
            b. Patient has an intolerance or hypersensitivity to ONE standard stimulant agent (e.g., methylphenidate) OR
            c. Patient has an FDA labeled contraindication to ONE standard stimulant agent (e.g., methylphenidate) OR
    C. Patient has another indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Patient is 18 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Lupkynis PA
Drug Name(s)
Lupkynis
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of active lupus nephritis (LN) AND
2. Patient will continue standard LN therapy [corticosteroids (e.g., methylprednisolone, prednisone), immunosuppressives (e.g., azathioprine, mycophenolate)] in combination with the requested agent AND
3. Patient will NOT be using the requested agent in combination with cyclophosphamide

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of active lupus nephritis (LN) AND
3. Patient will continue standard LN therapy [corticosteroids (e.g., methylprednisolone, prednisone), immunosuppressives (e.g., azathioprine, mycophenolate)] in combination with the requested agent AND
4. Patient has had clinical benefit with the requested agent AND
5. Patient will NOT be using the requested agent in combination with cyclophosphamide
Age Restriction:
Patient is 18 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Mavyret PA
Drug Name(s)
Mavyret
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of hepatitis C confirmed by serological markers OR
    B. Patient is a hepatitis C virus (HCV) - uninfected solid organ transplant recipient AND BOTH of the following:
        i. Patient received an HCV - viremic donor organ AND
        ii. The requested agent is being used for prophylaxis AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The requested dose is within FDA labeled dosing or supported in AASLD/IDSA guideline dosing for the requested indication AND
5. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. Patient has an FDA labeled contraindication or hypersensitivity to TWO preferred agents: Epclusa and Harvoni for supported genotypes OR
    D. Prescriber has provided information based on FDA approved labeling or AASLD/IDSA guidelines supporting the use of the non-preferred agent for the patient's diagnosis and genotype over TWO preferred agents: Epclusa and Harvoni for supported genotypes
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported
Other Criteria:

Prior Authorization Group Description:
Memantine ER PA
Drug Name(s)
Memantine Hydrochloride Er
Namenda Xr
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients greater than or equal to 30 years of age
Criteria for approval require the following:
1. Patient is younger than 30 years of age AND ONE of the following:
    A. Patient has a diagnosis of moderate to severe dementia of the Alzheimer's type OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Memantine PA
Drug Name(s)
Memantine Hcl Titration Pak
Memantine Hydrochloride
Namenda
Namenda Titration Pak
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients greater than or equal to 30 years of age
Criteria for approval require the following:
1. Patient is younger than 30 years of age AND ONE of the following:
    A. Patient has a diagnosis of moderate to severe dementia of the Alzheimer's type OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Methamphetamine PA
Drug Name(s)
Methamphetamine Hcl
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used to promote weight loss AND FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Methylin PA
Drug Name(s)
Methylin
Methylphenidate Hydrochloride (Methylin)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Methylphenidate Capsule PA
Drug Name(s)
Methylphenidate Hydrochloride Cd
Methylphenidate Hydrochloride Er Capsule
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Methylphenidate Chewable PA
Drug Name(s)
Methylphenidate Hydrochloride Chewable
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Methylphenidate ER Tablet PA
Drug Name(s)
Methylphenidate Hydrochloride Er Tablet
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Methylphenidate LA Capsule PA
Drug Name(s)
Methylphenidate Hydrochloride Er Capsule (La)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Methylphenidate Patch PA
Drug Name(s)
Daytrana
MethylphenidatePatch
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Miebo PA
Drug Name(s)
Miebo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Migranal PA
Drug Name(s)
Dihydroergotamine Mesylate Spray
Migranal
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. The requested agent will be used for the treatment of acute migraine with or without aura AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to TWO triptan agents with differing active ingredients (e.g., sumatriptan, rizatriptan) OR
    B. Patient has an intolerance or hypersensitivity to TWO triptan agents with differing active ingredients OR
    C. Patient has an FDA labeled contraindication to TWO triptan agents with differing active ingredients AND
3. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, acute CGRP)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. The requested agent will be used for the treatment of acute migraine with or without aura AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, acute CGRP)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Modafinil PA
Drug Name(s)
Modafinil
Provigil
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another target agent (i.e., armodafinil)
Age Restriction:
Patient is 17 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Mounjaro PA
Drug Name(s)
Mounjaro
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of type 2 diabetes mellitus AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. BOTH of the following:
        i. ONE of the following:
            1. Patient's medication history includes use of an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) within the past 90 days OR
            2. Patient had an ineffective treatment response to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            3. Patient has an intolerance or hypersensitivity to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            4. Patient has an FDA labeled contraindication to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Avonex
Drug Name(s)
Avonex
Avonex Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Bafiertam
Drug Name(s)
Bafiertam
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Betaseron
Drug Name(s)
Betaseron
Extavia
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA - Dimethyl Fumarate
Drug Name(s)
Dimethyl Fumarate
Dimethyl Fumarate Starterpack
Tecfidera
Tecfidera Starter Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Fingolimod
Drug Name(s)
Fingolimod
Gilenya
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication AND
3. Prescriber has performed an electrocardiogram within 6 months prior to initiating treatment

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Glatiramer
Drug Name(s)
Copaxone
Glatiramer Acetate
Glatopa
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Kesimpta
Drug Name(s)
Kesimpta
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Mavenclad
Drug Name(s)
Mavenclad
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) for the requested indication AND
3. The requested dose is within FDA labeled dosing for the requested indication AND
4. The total cumulative duration of treatment with Mavenclad (cladribine) has not exceeded 4 treatment cycles
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
No prior use approve 2 years, Prior use approve remainder of 2 years of total cumulative therapy
Other Criteria:

Prior Authorization Group Description:
MS PA – Mayzent
Drug Name(s)
Mayzent
Mayzent Starter Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Plegridy
Drug Name(s)
Plegridy
Plegridy Starter Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Ponvory
Drug Name(s)
Ponvory
Ponvory 14-Day Starter Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Rebif
Drug Name(s)
Rebif
Rebif Rebidose
Rebif Rebidose Titration Pack
Rebif Titration Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Tascenso
Drug Name(s)
Tascenso Odt
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication AND
3. Prescriber has performed an electrocardiogram within 6 months prior to initiating treatment

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Teriflunomide
Drug Name(s)
Aubagio
Teriflunomide
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Tysabri
Drug Name(s)
Tysabri
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. Patient has ONE of the following diagnoses:
        i. Relapsing form of Multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease AND ONE of the following:
            a. Prescriber states the patient has highly active disease OR
            b. ONE of the following:
                1. Patient has tried and had an inadequate response to TWO preferred agents (Avonex, Betaseron, Copaxone, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Mayzent, Plegridy, teriflunomide, Vumerity) OR
                2. Patient has an intolerance or hypersensitivity to TWO preferred agents (Avonex, Betaseron, Copaxone, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Mayzent, Plegridy, teriflunomide, Vumerity) OR
                3. Patient has an FDA labeled contraindication to TWO preferred agents (Avonex, Betaseron, Copaxone, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Mayzent, Plegridy, teriflunomide, Vumerity) OR

Initial criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months for MS, for CD 16 weeks for initial and 12 months renewal
Other Criteria:
        ii. Moderately to severely active Crohn's disease (CD) AND BOTH of the following:
            a. ONE of the following:
                1. Patient has tried and had an inadequate response to ONE conventional CD therapy (e.g., 6-mercaptopurine, azathioprine, corticosteroids, methotrexate) OR

2. Patient has an intolerance or hypersensitivity to ONE conventional CD therapy (e.g., 6-mercaptopurine, azathioprine, corticosteroids, methotrexate) OR
3. Patient has an FDA labeled contraindication to ONE conventional CD therapy (e.g., 6-mercaptopurine, azathioprine, corticosteroids, methotrexate) AND

b. ONE of the following:

1. Patient has tried and had an inadequate response to ONE preferred biologic agent (Humira, Skyrizi, or Stelara) for the treatment of CD OR
2. Patient has an intolerance or hypersensitivity to ONE preferred biologic agent (Humira, Skyrizi, or Stelara) OR
3. Patient has an FDA labeled contraindication to ONE preferred biologic agent (Humira, Skyrizi, or Stelara) AND

3. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Prior Authorization Group Description:
MS PA – Vumerity
Drug Name(s)
Vumerity
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
MS PA – Zeposia
Drug Name(s)
Zeposia
Zeposia Starter Kit
Zeposia 7-Day Starter Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication AND
3. ONE of the following:
    i. The requested diagnosis is NOT moderately to severely active ulcerative colitis (UC) OR
    ii. The requested diagnosis is moderately to severely active UC AND BOTH of the following:
        1. ONE of the following:
            a. Patient has tried and had an inadequate response to at least ONE conventional agent (e.g., 5-aminosalicylates [including balsalazide, mesalamine, olsalazine, sulfasalazine], mercaptopurine, azathioprine, corticosteroids [including budesonide EC capsule]) used in the treatment of UC OR
            b. Patient has severely active UC OR
            c. Patient has an intolerance or hypersensitivity to ONE of the conventional agents used in the treatment of UC OR
            d. Patient has an FDA labeled contraindication to at least ONE of the conventional agents used in the treatment of UC AND
        2. ONE of the following:
            a. Patient has tried and had an inadequate response to ONE preferred biologic agent (Humira or Stelara) for the treatment of UC OR
            b. Patient has an intolerance or hypersensitivity to ONE preferred biologic agent (Humira or Stelara) OR
            c. Patient has an FDA labeled contraindication to ONE preferred biologic agent (Humira or Stelara)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Mulpleta PA
Drug Name(s)
Mulpleta
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of thrombocytopenia AND
2. Patient has chronic liver disease AND
3. Patient has a platelet count less than 50 X 10^9/L AND
4. Patient is scheduled to undergo a procedure with an associated risk of bleeding (e.g., gastrointestinal endoscopy, liver biopsy, bronchoscopy, dental procedure) AND
5. The requested dose is within FDA labeled dosing for the requested indication AND
6. The length of therapy of the requested agent is within the FDA labeled duration for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 1 month
Other Criteria:

Prior Authorization Group Description:
Myalept PA
Drug Name(s)
Myalept
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has leptin deficiency associated with a diagnosis of either congenital generalized lipodystrophy (CGL) or acquired generalized lipodystrophy (AGL) AND
2. Prescriber has provided the patient's baseline levels for HbA1C, triglycerides, and fasting insulin, measured prior to beginning therapy with the requested agent AND
3. Patient also has at least ONE of the complications related to lipodystrophy: diabetes mellitus, hypertriglyceridemia (200 mg/dL or higher), and/or high fasting insulin (30µU/mL or higher) AND
4. Patient has tried and had an inadequate response to maximum tolerable dosing of a conventional agent for the additional diagnosis AND
5. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has leptin deficiency associated with a diagnosis of either congenital generalized lipodystrophy (CGL) or acquired generalized lipodystrophy (AGL) AND
3. Patient has had improvement or stabilization with the requested agent as indicated by change from baseline level of at least ONE of the following:
    A. HbA1C
    B. Triglycerides
    C. Fasting insulin AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Conventional agent examples include:
Hypertriglyceridemia: statins, fenofibrates, Omega-3-Acid Ethyl Esters (generic Lovaza)
Diabetes/high fasting insulin: insulin, sulfonylurea/sulfonylurea combination, metformin/metformin combination

Prior Authorization Group Description:
Myfembree PA
Drug Name(s)
Myfembree
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. ONE of the following:
    A. BOTH of the following:
        i. Patient has a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) AND
        ii. Patient's diagnosis of uterine fibroids was confirmed via imaging (e.g., ultrasound) OR
    B. Patient has a diagnosis of moderate to severe pain associated with endometriosis AND
2. Patient is premenopausal AND
3. Patient will NOT be using the requested agent in combination with another GnRH antagonist agent [e.g., Orilissa (elagolix), Oriahnn (elagolix, estradiol, norethindrone acetate)] for the requested indication AND
4. The requested dose is within FDA labeled dosing for the requested indication AND
5. ONE of the following:
    A. Patient is initiating therapy with the requested agent OR
    B. BOTH of the following:
        i. Patient is continuing therapy with the requested agent and the prescriber has provided information indicating the number of months the patient has been on therapy with the requested agent AND
        ii. The total duration of treatment with the requested agent has NOT exceeded 24 months per lifetime
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
For no prior Myfembree use:
24 months
For prior Myfembree use:
Remainder of 24 months
Other Criteria:

Prior Authorization Group Description:
Natpara PA
Drug Name(s)
Natpara
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Increased baseline risk for osteosarcoma (e.g., Paget's disease of bone, unexplained elevations of alkaline phosphatase, hereditary disorders predisposing to osteosarcoma, history of external beam or implant radiation therapy involving the skeleton, pediatric and young adult patients with open epiphyses)
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hypocalcemia associated with hypoparathyroidism AND
2. Patient does NOT have a baseline vitamin D level below the testing laboratory's lower limit of normal AND
3. Patient's baseline serum calcium level (albumin-corrected) is above 7.5 mg/dL AND
4. Patient will NOT be using the requested agent in combination with alendronate for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of hypocalcemia associated with hypoparathyroidism AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with alendronate for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, nephrologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Nexletol PA
Drug Name(s)
Nexletol
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has ONE of the following:
    A. A diagnosis of heterozygous familial hypercholesterolemia (HeFH) AND ONE of the following:
        i. Genetic confirmation of one mutant allele at the LDLR, Apo-B, PCSK9, or 1/LDLRAP1 gene OR
        ii. History of LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) (pretreatment) OR
        iii. Patient has clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthoma, or xanthelasma) OR
        iv. Patient has “definite” or “possible” familial hypercholesterolemia as defined by the Simon Broome criteria OR
        v. Patient has a Dutch Lipid Clinic Network criteria score of greater than 5 OR
    B. A diagnosis of established atherosclerotic cardiovascular disease (ASCVD) defined as having ONE of the following:
        i. Acute coronary syndrome
        ii. History of myocardial infarction
        iii. Stable or unstable angina
        iv. Coronary or other arterial revascularization
        v. Stroke
        vi. Transient ischemic attack
        vii. Peripheral arterial disease, including aortic aneurysm, presumed to be of atherosclerotic origin AND
2. ONE of the following:
    A. Patient is on maximally tolerated statin therapy OR
    B. Patient has an intolerance to TWO different statins OR
    C. Patient has an FDA labeled contraindication to a statin
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient’s diagnosis (e.g., cardiologist, endocrinologist) or the prescriber has consulted with a specialist in the area of the patient’s diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan’s Prior Authorization criteria AND

2. Patient has ONE of the following:
    A. A diagnosis of heterozygous familial hypercholesterolemia (HeFH) OR
    B. A diagnosis of established atherosclerotic cardiovascular disease (ASCVD) AND
3. ONE of the following:
    A. Patient is on maximally tolerated statin therapy OR
    B. Patient has an intolerance to TWO different statins OR
    C. Patient has an FDA labeled contraindication to a statin AND
4. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Nexlizet PA
Drug Name(s)
Nexlizet
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has ONE of the following:
    A. A diagnosis of heterozygous familial hypercholesterolemia (HeFH) AND ONE of the following:
        i. Genetic confirmation of one mutant allele at the LDLR, Apo-B, PCSK9, or 1/LDLRAP1 gene OR
        ii. History of LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) (pretreatment) OR
        iii. Patient has clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthoma, or xanthelasma) OR
        iv. Patient has "definite" or "possible" familial hypercholesterolemia as defined by the Simon Broome criteria OR
        v. Patient has a Dutch Lipid Clinic Network criteria score of greater than 5 OR
    B. A diagnosis of established atherosclerotic cardiovascular disease (ASCVD) defined as having ONE of the following:
        i. Acute coronary syndrome
        ii. History of myocardial infarction
        iii. Stable or unstable angina
        iv. Coronary or other arterial revascularization
        v. Stroke
        vi. Transient ischemic attack
        vii. Peripheral arterial disease, including aortic aneurysm, presumed to be of atherosclerotic origin AND
2. ONE of the following:
    A. Patient is on maximally tolerated statin therapy OR
    B. Patient has an intolerance to TWO different statins OR
    C. Patient has an FDA labeled contraindication to a statin
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist, endocrinologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND

2. Patient has ONE of the following:
    A. A diagnosis of heterozygous familial hypercholesterolemia (HeFH) OR
    B. A diagnosis of established atherosclerotic cardiovascular disease (ASCVD) AND
3. ONE of the following:
    A. Patient is on maximally tolerated statin therapy OR
    B. Patient has an intolerance to TWO different statins OR
    C. Patient has an FDA labeled contraindication to a statin AND
4. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Nocdurna PA
Drug Name(s)
Nocdurna
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of nocturia due to nocturnal polyuria (awakening at least two times per night to void) AND
2. Diagnosis was confirmed by a nighttime urine production greater than one third of 24-hour urine collection AND
3. Patient's serum sodium concentration is within normal range [between 135 to 145 mEq/L (mmol/L) or within testing laboratory's normal range]

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of nocturia due to nocturnal polyuria (awakening at least two times per night to void) AND
3. Patient's serum sodium concentration is within normal range [between 135 to 145 mEq/L (mmol/L) or within testing laboratory's normal range] AND
4. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Nourianz PA
Drug Name(s)
Nourianz
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. The requested agent will be used as adjunctive treatment in patients with Parkinson's disease experiencing "off" episodes AND
2. The requested agent will be used in combination with levodopa/carbidopa agents
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Nucala PA
Drug Name(s)
Nucala
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of severe asthma with an eosinophilic phenotype AND the following:
        i. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LRTA, LAMA, theophylline) in combination with the requested agent OR
    B. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the following:
        i. ONE of the following:
            a. Patient is currently being treated with a maximally tolerated oral corticosteroid OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an oral corticosteroid OR
    C. Patient has a diagnosis of hypereosinophilic syndrome (HES) for 6 months or more without an identifiable non-hematologic secondary cause AND the following:
        i. ONE of the following:
            a. Patient is currently being treated with a maximally tolerated oral corticosteroid OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an oral corticosteroid OR
    D. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND
2. Patient will NOT be using the requested agent in combination with Xolair, Dupixent, or with another injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Fasenra) for the requested indication AND
3. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
For diagnosis of severe asthma with an eosinophilic phenotype, patient is 6 years of age or over. For diagnosis of EGPA, patient is 18 years of age or over. For diagnosis of HES, patient is 12 years of age or over. For diagnosis of CRSwNP, patient is 18 years of age or over.
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, otolaryngologist, pathologist, pulmonologist, rheumatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of severe asthma with an eosinophilic phenotype AND the following:
        i. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent OR
    B. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the following:
        i. ONE of the following:
            a. Patient is currently being treated with maintenance therapy with oral corticosteroid
            OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to oral corticosteroid OR
    C. Patient has a diagnosis of hypereosinophilic syndrome (HES) for 6 months or more without an identifiable non-hematologic secondary cause AND the following:
        i. ONE of the following:
            a. Patient is currently being treated with maintenance therapy with oral corticosteroid
            OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to oral corticosteroid OR
    D. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with Xolair, Dupixent, or with another injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Fasenra) for the requested indication AND
5. The requested dose is within FDA labeled dosing for the requested indication

Prior Authorization Group Description:
Nuedexta PA
Drug Name(s)
Nuedexta
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of pseudobulbar affect OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. Patient will NOT be using the requested agent in combination with a monoamine oxidase inhibitor (MAOI) [e.g., Marplan (isocarboxazid), Nardil (phenelzine), and Parnate (tranylcypromine)]
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Nuplazid PA
Drug Name(s)
Nuplazid
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Nurtec PA
Drug Name(s)
Nurtec
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of migraine AND
2. ONE of the following:
    A. The requested agent is being used for the treatment of acute migraine with or without aura AND BOTH of the following:
        i. ONE of the following:
            a. Patient has tried and had an inadequate response to a triptan (e.g., sumatriptan, rizatriptan) agent OR
            b. Patient has an intolerance, or hypersensitivity to a triptan OR
            c. Patient has an FDA labeled contraindication to a triptan AND
        ii. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP) OR
    B. The requested agent is being used for migraine prophylaxis AND ALL of the following:
        i. Patient has 4 migraine headaches or more per month AND
        ii. ONE of the following:
            a. Patient has tried and had an inadequate response to a conventional migraine prophylaxis agent [e.g., beta blockers (propranolol), anticonvulsants (divalproex, topiramate)] OR
            b. Patient has an intolerance, or hypersensitivity to a conventional migraine prophylaxis agent OR
            c. Patient has an FDA labeled contraindication to a conventional migraine prophylaxis agent AND
        iii. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 Months
Other Criteria:
Criteria for renewal require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of migraine AND
3. ONE of the following:

A. The requested agent is being used for the treatment of acute migraine with or without aura AND BOTH of the following:

i. Patient has had clinical benefit with the requested agent AND

ii. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP) OR

B. The requested agent is being used for migraine prophylaxis AND BOTH of the following:

i. Patient has had clinical benefit with the requested agent AND

ii. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis

Prior Authorization Group Description:
Ocaliva PA
Drug Name(s)
Ocaliva
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of primary biliary cholangitis (PBC) confirmed by at least TWO of the following:
    A. There is biochemical evidence of cholestasis with an alkaline phosphatase (ALP) elevation
    B. Presence of antimitochondrial antibody (AMA): a titer greater than 1:80 OR a level that is above the testing laboratory's upper limit of the normal range
    C. If the AMA is negative or present only in low titer (less than or equal to 1:80), presence of other PBC-specific autoantibodies, including sp100 or gp210
    D. Histologic evidence of nonsuppurative destruction cholangitis and destruction of interlobular bile ducts AND
2. ONE of the following:
    A. Patient does NOT have cirrhosis OR
    B. Patient has compensated cirrhosis with NO evidence of portal hypertension AND
3. Prescriber has measured the patient's alkaline phosphatase (ALP) level AND total bilirubin level AND
4. ONE of the following:
    A. BOTH of the following:
        i. Patient has tried and had an inadequate response to ursodiol AND
        ii. The requested agent will be used in combination with ursodiol OR
    B. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ursodiol
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of primary biliary cholangitis (PBC) AND
3. ONE of the following:
    A. Patient does NOT have cirrhosis OR
    B. Patient has compensated cirrhosis with NO evidence of portal hypertension AND
4. ONE of the following:
    A. The requested agent will be used in combination with ursodiol OR
    B. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ursodiol AND

5. Patient has had improvements or stabilization with the requested agent as indicated by BOTH of the following:

A. Decrease in alkaline phosphatase (ALP) level from baseline AND

B. Total bilirubin is less than or equal to the upper limit of normal (ULN)

Prior Authorization Group Description:
Ofev PA
Drug Name(s)
Ofev
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF) AND
        ii. Patient has no known explanation for interstitial lung disease (ILD) or pulmonary fibrosis (e.g., radiation, drugs, metal dusts, sarcoidosis, or any connective tissue disease known to cause ILD) OR
    B. BOTH of the following:
        i. Patient has a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) AND
        ii. Patient's diagnosis has been confirmed on high-resolution computed tomography (HRCT) or chest radiography scans OR
    C. BOTH of the following:
        i. Patient has a diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype AND
        ii. Patient's diagnosis has been confirmed on high-resolution computed tomography (HRCT)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of ONE of the following:
    A. Idiopathic pulmonary fibrosis (IPF) OR
    B. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) OR
    C. Chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., pathologist, pulmonologist, radiologist, rheumatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Oncology Immunotherapy PA – Bavencio
Drug Name(s)
Bavencio
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. The requested agent is FDA labeled or supported in CMS approved compendia as first-line therapy for the requested indication OR
            b. Patient has tried appropriate FDA labeled or CMS approved compendia supported therapy that are indicated as first-line therapy for the requested agent OR
            c. Patient has an intolerance or hypersensitivity to the first-line therapy for the requested indication OR
            d. Patient has an FDA labeled contraindication to the first-line therapy for the requested indication AND
        iii. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Oncology Immunotherapy PA – Imfinzi
Drug Name(s)
Imfinzi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. The requested agent is FDA labeled or supported in CMS approved compendia as first-line therapy for the requested indication OR
            b. Patient has tried appropriate FDA labeled or CMS approved compendia supported therapy that are indicated as first-line therapy for the requested agent OR
            c. Patient has an intolerance or hypersensitivity to the first-line therapy for the requested indication OR
            d. Patient has an FDA labeled contraindication to the first-line therapy for the requested indication AND
        iii. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Oncology Immunotherapy PA – Jemperli
Drug Name(s)
Jemperli
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. The requested agent is FDA labeled or supported in CMS approved compendia as first-line therapy for the requested indication OR
            b. Patient has tried appropriate FDA labeled or CMS approved compendia supported therapy that are indicated as first-line therapy for the requested agent OR
            c. Patient has an intolerance or hypersensitivity to the first-line therapy for the requested indication OR
            d. Patient has an FDA labeled contraindication to the first-line therapy for the requested indication AND
        iii. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Oncology Immunotherapy PA – Keytruda
Drug Name(s)
Keytruda
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. The requested agent is FDA labeled or supported in CMS approved compendia as first-line therapy for the requested indication OR
            b. Patient has tried appropriate FDA labeled or CMS approved compendia supported therapy that are indicated as first-line therapy for the requested agent OR
            c. Patient has an intolerance or hypersensitivity to the first-line therapy for the requested indication OR
            d. Patient has an FDA labeled contraindication to the first-line therapy for the requested indication AND
        iii. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Oncology Immunotherapy PA – Libtayo
Drug Name(s)
Libtayo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. The requested agent is FDA labeled or supported in CMS approved compendia as first-line therapy for the requested indication OR
            b. Patient has tried appropriate FDA labeled or CMS approved compendia supported therapy that are indicated as first-line therapy for the requested agent OR
            c. Patient has an intolerance or hypersensitivity to the first-line therapy for the requested indication OR
            d. Patient has an FDA labeled contraindication to the first-line therapy for the requested indication AND
        iii. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Oncology Immunotherapy PA – Opdivo
Drug Name(s)
Opdivo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. The requested agent is FDA labeled or supported in CMS approved compendia as first-line therapy for the requested indication OR
            b. Patient has tried appropriate FDA labeled or CMS approved compendia supported therapy that are indicated as first-line therapy for the requested agent OR
            c. Patient has an intolerance or hypersensitivity to the first-line therapy for the requested indication OR
            d. Patient has an FDA labeled contraindication to the first-line therapy for the requested indication AND
        iii. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Oncology Immunotherapy PA – Tecentriq
Drug Name(s)
Tecentriq
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. The requested agent is FDA labeled or supported in CMS approved compendia as first-line therapy for the requested indication OR
            b. Patient has tried appropriate FDA labeled or CMS approved compendia supported therapy that are indicated as first-line therapy for the requested agent OR
            c. Patient has an intolerance or hypersensitivity to the first-line therapy for the requested indication OR
            d. Patient has an FDA labeled contraindication to the first-line therapy for the requested indication AND
        iii. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Oncology Immunotherapy PA – Yervoy
Drug Name(s)
Yervoy
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. The requested agent is FDA labeled or supported in CMS approved compendia as first-line therapy for the requested indication OR
            b. Patient has tried appropriate FDA labeled or CMS approved compendia supported therapy that are indicated as first-line therapy for the requested agent OR
            c. Patient has an intolerance or hypersensitivity to the first-line therapy for the requested indication OR
            d. Patient has an FDA labeled contraindication to the first-line therapy for the requested indication AND
        iii. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Ophthalmic Immunomodulators PA – Cequa
Drug Name(s)
Cequa
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Ophthalmic Immunomodulators PA – Verkazia
Drug Name(s)
Verkazia
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Ophthalmic Immunomodulators PA – Xiidra
Drug Name(s)
Xiidra
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Opioids ER PA - Buprenorphine Pain
Drug Name(s)
Belbuca
Buprenorphine
Butrans
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
    B. Patient has a diagnosis of pain due to sickle cell disease OR
    C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. ALL of the following:
            a. Prescriber has provided documentation of a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
            b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
            c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
            d. ONE of the following:
                1. Patient's medication history includes use of an immediate-acting opioid OR
                2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR
                3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND
            e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND
            f. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Opioids ER PA - Fentanyl Patch
Drug Name(s)
Fentanyl
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
    B. Patient has a diagnosis of pain due to sickle cell disease OR
    C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. ALL of the following:
            a. Prescriber has provided documentation of a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
            b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
            c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
            d. ONE of the following:
                1. Patient's medication history includes use of an immediate-acting opioid OR
                2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR
                3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND
            e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND
            f. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Opioids ER PA – Hydrocodone
Drug Name(s)
Hydrocodone Bitartrate Er
Hysingla Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
    B. Patient has a diagnosis of pain due to sickle cell disease OR
    C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. ALL of the following:
            a. Prescriber has provided documentation of a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
            b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
            c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
            d. ONE of the following:
                1. Patient's medication history includes use of an immediate-acting opioid OR
                2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR
                3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND
            e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND
            f. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Opioids ER PA – Hydromorphone
Drug Name(s)
Hydromorphone Hydrochloride Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
    B. Patient has a diagnosis of pain due to sickle cell disease OR
    C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. ALL of the following:
            a. Prescriber has provided documentation of a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
            b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
            c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
            d. ONE of the following:
                1. Patient's medication history includes use of an immediate-acting opioid OR
                2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR
                3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND
            e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND
            f. Patient does NOT have any FDA labeled contraindications to the requested agent

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Opioids ER PA – Morphine
Drug Name(s)
Morphine Sulfate Er
Ms Contin
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
    B. Patient has a diagnosis of pain due to sickle cell disease OR
    C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. ALL of the following:
            a. Prescriber has provided documentation of a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
            b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
            c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
            d. ONE of the following:
                1. Patient's medication history includes use of an immediate-acting opioid OR
                2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR
                3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND
            e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND
            f. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Opioids ER PA – Oxycodone
Drug Name(s)
Oxycodone Hcl Er
Oxycontin
Xtampza Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
    B. Patient has a diagnosis of pain due to sickle cell disease OR
    C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. ALL of the following:
            a. Prescriber has provided documentation of a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
            b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
            c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
            d. ONE of the following:
                1. Patient's medication history includes use of an immediate-acting opioid OR
                2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR
                3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND
            e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND
            f. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Opioids ER PA – Oxymorphone
Drug Name(s)
Oxymorphone Hydrochloride Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
    B. Patient has a diagnosis of pain due to sickle cell disease OR
    C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. ALL of the following:
            a. Prescriber has provided documentation of a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
            b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
            c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
            d. ONE of the following:
                1. Patient's medication history includes use of an immediate-acting opioid OR
                2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR
                3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND
            e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND
            f. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Opioids ER PA – Tapentadol
Drug Name(s)
Nucynta Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
    B. Patient has a diagnosis of pain due to sickle cell disease OR
    C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. ALL of the following:
            a. Prescriber has provided documentation of a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
            b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
            c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
            d. ONE of the following:
                1. Patient's medication history includes use of an immediate-acting opioid OR
                2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR
                3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND
            e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND
            f. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Opioids ER PA – Tramadol
Drug Name(s)
Conzip
Tramadol Hcl Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
    B. Patient has a diagnosis of pain due to sickle cell disease OR
    C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. ALL of the following:
            a. Prescriber has provided documentation of a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
            b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
            c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
            d. ONE of the following:
                1. Patient's medication history includes use of an immediate-acting opioid OR
                2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR
                3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND
            e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND
            f. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Opzelura PA
Drug Name(s)
Opzelura
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of mild to moderate atopic dermatitis AND ALL of the following:
        i. The requested agent will be used for short-term and non-continuous chronic treatment AND
        ii. Patient is NOT immunocompromised AND
        iii. ONE of the following:
            a. Patient has tried and failed a topical steroid (e.g., triamcinolone) OR
            b. Patient has an intolerance or hypersensitivity to a topical steroid OR
            c. Patient has an FDA labeled contraindication to a topical steroid AND
        iv. ONE of the following:
            a. Patient has tried and failed a topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus) OR
            b. Patient has an intolerance or hypersensitivity to a topical calcineurin inhibitor OR
            c. Patient has an FDA labeled contraindication to a topical calcineurin inhibitor OR
    B. Patient has a diagnosis of nonsegmental vitiligo AND
2. Patient will NOT be using the requested agent in combination with other biologic immunomodulator agents, other JAK inhibitors, OR potent immunosuppressants (e.g., azathioprine, cyclosporine) AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of mild to moderate atopic dermatitis AND BOTH of the following:
        i. The requested agent will be used for short-term and non-continuous chronic treatment AND
        ii. Patient is NOT immunocompromised OR
    B. Patient has a diagnosis of nonsegmental vitiligo AND
2. Patient has had clinical benefit with the requested agent AND
3. Patient will NOT be using the requested agent in combination with other biologic immunomodulator agents, other JAK inhibitors, OR potent immunosuppressants (e.g., azathioprine, cyclosporine) AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:

For diagnosis of mild to moderate atopic dermatitis, patient is 12 years of age or over. For diagnosis of nonsegmental vitiligo, patient is 12 years of age or over.

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, dermatologist, immunologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Initial and Renewal: 3 months for atopic dermatitis, other diagnosis - see Other Criteria

Other Criteria:

Initial: 6 months for nonsegmental vitiligo, Renewal: 12 months for nonsegmental vitiligo

Prior Authorization Group Description:
Oral Immunotherapy Agents PA – Grastek
Drug Name(s)
Grastek
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of allergic rhinitis, with or without conjunctivitis AND
2. Patient's diagnosis is confirmed with ONE of the following:
    A. Positive skin test to ONE of the pollen extracts included in the requested agent OR
    B. IgE specific antibodies to ONE of the extracts included in the requested agent: Timothy grass or cross-reactive grass AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to TWO standard allergy medications, one of which was an intranasal corticosteroid OR
    B. Patient has an intolerance or hypersensitivity to TWO standard allergy medications, one of which was an intranasal corticosteroid OR
    C. Patient has an FDA labeled contraindication to TWO standard allergy medications, one of which was an intranasal corticosteroid AND
4. Patient will NOT be using the requested agent in combination with a subcutaneous injectable immunotherapy agent AND
5. The requested agent will be started, or has already been started, 3 to 4 months before the expected onset of the applicable pollen season AND
6. The first dose is given in the clinic/hospital under direct supervision from the provider for a period of at least 30 minutes AND
7. Patient has been prescribed epinephrine auto-injector for at home emergency use
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Standard allergy medications:
Oral antihistamines, oral corticosteroids, intranasal corticosteroids, intranasal antihistamines, or leukotriene inhibitors

Prior Authorization Group Description:
Oral Immunotherapy Agents PA – Odactra
Drug Name(s)
Odactra
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of allergic rhinitis, with or without conjunctivitis AND
2. Patient's diagnosis is confirmed with ONE of the following:
    A. Positive skin test to licensed house dust mite allergen extracts OR
    B. IgE specific antibodies to ONE of the extracts included in the requested agent: Dermatophagoides farinae or Dermatophagoides pteronyssinus AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to TWO standard allergy medications, one of which was an intranasal corticosteroid OR
    B. Patient has an intolerance or hypersensitivity to TWO standard allergy medications, one of which was an intranasal corticosteroid OR
    C. Patient has an FDA labeled contraindication to TWO standard allergy medications, one of which was an intranasal corticosteroid AND
4. Patient will NOT be using the requested agent in combination with a subcutaneous injectable immunotherapy agent AND
5. The first dose is given in the clinic/hospital under direct supervision from the provider for a period of at least 30 minutes AND
6. Patient has been prescribed epinephrine auto-injector for at home emergency use
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Standard allergy medications:
Oral antihistamines, oral corticosteroids, intranasal corticosteroids, intranasal antihistamines, or leukotriene inhibitors

Prior Authorization Group Description:
Oral Immunotherapy Agents PA – Oralair
Drug Name(s)
Oralair
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of allergic rhinitis, with or without conjunctivitis AND
2. Patient's diagnosis is confirmed with ONE of the following:
    A. Positive skin test to ONE of the pollen extracts included in the requested agent OR
    B. IgE specific antibodies to ONE of the extracts included in the requested agent: Sweet vernal, orchard, perennial rye, Timothy, or Kentucky blue grass AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to TWO standard allergy medications, one of which was an intranasal corticosteroid OR
    B. Patient has an intolerance or hypersensitivity to TWO standard allergy medications, one of which was an intranasal corticosteroid OR
    C. Patient has an FDA labeled contraindication to TWO standard allergy medications, one of which was an intranasal corticosteroid AND
4. Patient will NOT be using the requested agent in combination with a subcutaneous injectable immunotherapy agent AND
5. The requested agent will be started, or has already been started, 3 to 4 months before the expected onset of the applicable pollen season AND
6. The first dose is given in the clinic/hospital under direct supervision from the provider for a period of at least 30 minutes AND
7. Patient has been prescribed epinephrine auto-injector for at home emergency use
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Standard allergy medications:
Oral antihistamines, oral corticosteroids, intranasal corticosteroids, intranasal antihistamines, or leukotriene inhibitors

Prior Authorization Group Description:
Oriahnn PA
Drug Name(s)
Oriahnn
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) AND
2. Patient's diagnosis of uterine fibroids was confirmed via imaging (e.g., ultrasound) AND
3. Patient is premenopausal AND
4. Patient will NOT be using the requested agent in combination with another GnRH antagonist agent [e.g., Orilissa (elagolix), Myfembree (relugolix, estradiol hemihydrate, norethindrone acetate)] for the requested indication AND
5. The requested dose is within FDA labeled dosing for the requested indication AND
6. ONE of the following:
    A. Patient is initiating therapy with the requested agent OR
    B. BOTH of the following:
        i. Patient is continuing therapy with the requested agent and the prescriber has provided information indicating the number of months the patient has been on therapy with the requested agent AND
        ii. The total duration of treatment with the requested agent has NOT exceeded 24 months per lifetime
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
For no prior Oriahnn use: 24 months
For Prior Oriahnn use: Remainder of 24 months
Other Criteria:

Prior Authorization Group Description:
Orilissa PA
Drug Name(s)
Orilissa
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of moderate to severe pain associated with endometriosis AND
2. ONE of the following:
    A. Patient has coexisting dyspareunia AND has not received 6 or more months of therapy with the requested agent OR
    B. Patient has coexisting moderate hepatic impairment (Child-Pugh Class B) AND has not received 6 or more months of therapy with the requested agent OR
    C. Patient does not have coexisting dyspareunia or moderate hepatic impairment (Child-Pugh Class B), AND has not received 24 or more months of therapy with the requested agent AND
3. Patient will NOT be using the requested agent in combination with another GnRH antagonist agent [e.g., Oriahnn (elagolix, estradiol, norethindrone acetate), Myfembree (relugolix, estradiol hemihydrate, norethindrone acetate)] for the requested indication AND
4. The requested dose is within FDA labeled dosing for the requested indication AND
5. ONE of the following:
    A. Patient is initiating therapy with the requested agent OR
    B. BOTH of the following:
        i. Patient is continuing therapy with the requested agent and the prescriber has provided information indicating the number of months the patient has been on therapy with the requested agent AND
        ii. The total duration of treatment with the requested agent has NOT exceeded 6 months per lifetime if patient has coexisting dyspareunia or moderate hepatic impairment, or 24 months per lifetime if the patient does NOT have coexisting dyspareunia or moderate hepatic impairment
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
For no prior Orilissa use and for prior Orilissa use, see Other Criteria for approval
Other Criteria:
No prior Orilissa use: Approve 6 months for coexisting dyspareunia OR moderate hepatic impairment, Approve 24 months for no coexisting condition

Prior Orilissa use: Approve remainder of 6 months for coexisting dyspareunia OR moderate hepatic impairment, Approve remainder of 24 months for no coexisting condition

Prior Authorization Group Description:
Orkambi PA
Drug Name(s)
Orkambi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. ONE of the following:
    A. Patient has the presence of the F508del mutation on both alleles (homozygous) of the CFTR gene confirmed by genetic testing OR
    B. Patient has another CFTR gene mutation(s) that is responsive to the requested agent, as indicated in the FDA label, confirmed by genetic testing AND
3. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of cystic fibrosis AND
3. Patient has had improvement or stabilization with the requested agent [e.g., improvement in FEV1 from baseline, increase in weight/BMI, improvement from baseline Cystic Fibrosis Questionnaire-Revised (CFQ-R) Respiratory Domain score, improvements in respiratory symptoms (cough, sputum production, and difficulty breathing), and/or reduced number of pulmonary exacerbations] AND
4. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cystic fibrosis, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Osphena PA
Drug Name(s)
Osphena
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Otezla PA
Drug Name(s)
Otezla
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ONE of the following:
1. BOTH of the following:
    A. Patient has ONE of the following diagnoses:
        i. Plaque psoriasis OR
        ii. Active psoriatic arthritis AND
    B. ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
        iii. Patient's medication history indicates use of a biologic immunomodulator agent for the same FDA labeled indication OR
        iv. Patient has tried and had an inadequate response to at least ONE conventional prerequisite agent for the requested indication OR
        v. Patient has an intolerance or hypersensitivity to at least ONE conventional prerequisite agent for the requested indication OR
        vi. Patient has an FDA labeled contraindication to at least ONE conventional prerequisite agent for the requested indication OR
2. Patient has a diagnosis of oral ulcers associated with Behcet's disease (BD)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of plaque psoriasis, active psoriatic arthritis, or oral ulcers associated with Behcet's disease (BD) AND
3. Patient has had clinical benefit with the requested agent (slowing of disease progression or decrease in symptom severity and/or frequency)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Formulary conventional agent required for diagnoses of plaque psoriasis or active psoriatic arthritis

Formulary conventional agents for plaque psoriasis include cyclosporine, methotrexate, tazarotene, topical calcitriol, or topical corticosteroids

Formulary conventional agents for active psoriatic arthritis include cyclosporine, leflunomide, methotrexate, or sulfasalazine

NO prerequisites are required for a diagnosis of oral ulcers associated with Behcet's disease (BD)

Prior Authorization Group Description:
Otrexup PA
Drug Name(s)
Otrexup
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to a generic methotrexate injectable agent OR
    B. Patient has an intolerance or hypersensitivity to a generic methotrexate injectable agent OR
    C. Patient has an FDA labeled contraindication to a generic methotrexate injectable agent OR
    D. Prescriber has provided information that the patient has a physical or a mental disability that would prevent the patient from using a generic methotrexate injectable agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Oxbryta PA
Drug Name(s)
Oxbryta
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of sickle cell disease AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to maximally tolerated dose of hydroxyurea OR
    B. Patient has an intolerance or hypersensitivity to hydroxyurea OR
    C. Patient has an FDA labeled contraindication to hydroxyurea

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of sickle cell disease AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Oxervate PA
Drug Name(s)
Oxervate
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of neurotrophic keratitis (NK) AND
2. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., ophthalmologist, optometrist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 8 weeks
Other Criteria:

Prior Authorization Group Description:
Oxlumo PA
Drug Name(s)
Oxlumo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by ONE of the following:
    A. Genetic testing of the AGXT gene indicates a pathogenic mutation OR
    B. Liver biopsy demonstrates absent or significantly reduced alanine:glyoxylate aminotransferase (AGT) activity AND
2. The requested agent will be used to lower urinary or plasma oxalate levels AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of primary hyperoxaluria type 1 (PH1) AND
3. The requested agent will be used to lower urinary or plasma oxalate levels AND
4. Patient has had clinical benefit with the requested agent AND
5. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, nephrologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal
Other Criteria:

Prior Authorization Group Description:
Ozempic PA
Drug Name(s)
Ozempic
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of type 2 diabetes mellitus AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. BOTH of the following:
        i. ONE of the following:
            1. Patient's medication history includes use of an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) within the past 90 days OR
            2. Patient had an ineffective treatment response to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            3. Patient has an intolerance or hypersensitivity to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            4. Patient has an FDA labeled contraindication to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            5. BOTH of the following:
                a. Patient has a diagnosis of established cardiovascular disease [e.g., myocardial infarction, stroke, any revascularization procedure, transient ischemic attack, unstable angina, amputation, symptomatic or asymptomatic coronary artery disease] AND
                b. The requested agent will be used to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Palforzia PA
Drug Name(s)
Palforzia
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of peanut allergy AND
2. Patient is/was 4-17 years of age at the time of initiating therapy AND
3. Patient has been prescribed epinephrine injection for at home emergency use AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Palynziq PA
Drug Name(s)
Palynziq
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of phenylketonuria (PKU) AND
2. Patient has a baseline blood Phe level greater than 600 micromol/L (10 mg/dL) AND
3. Patient will NOT be using the requested agent in combination with sapropterin for the requested indication AND
4. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of phenylketonuria (PKU) AND
3. ONE of the following:
    a. Patient's blood Phe levels are being maintained within the acceptable range OR
    b. Patient has had a decrease in blood Phe level from baseline AND
4. Patient will NOT be using the requested agent in combination with sapropterin for the requested indication AND
5. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., metabolic or genetic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Initial approval will be for 9 months, renewal approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Panretin PA
Drug Name(s)
Panretin
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of cutaneous lesions associated with AIDS-related Kaposi's sarcoma (KS) OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. ONE of the following:
            1. BOTH of the following:
                a. Patient has a diagnosis of cutaneous lesions associated with AIDS-related Kaposi's sarcoma (KS) AND
                b. Patient does NOT require systemic anti-Kaposi's sarcoma therapy OR
            2. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, dermatologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND
        iii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Panzyga PA
Drug Name(s)
Panzyga
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ONE of the following:
1. Patient has ONE of the following diagnoses:
    A. Primary immunodeficiency [e.g., congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency] OR
    B. B-cell chronic lymphocytic leukemia OR multiple myeloma AND ONE of the following:
        i. Patient has a history of infections OR
        ii. Patient has evidence of specific antibody deficiency OR
        iii. Patient has hypogammaglobulinemia OR
    C. Idiopathic thrombocytopenia purpura AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone), or immunosuppressants (e.g., azathioprine)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    D. Dermatomyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone) or immunosuppressants (e.g., azathioprine)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    E. Polymyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., corticosteroids (e.g., methylprednisolone) or immunosuppressants (e.g., azathioprine)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    F. Severe rheumatoid arthritis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g., tumor necrosis factor antagonists (e.g., Humira), DMARDS (e.g., methotrexate)] OR
        ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

Criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 6 months for indications in Other Criteria, 12 months for all others

Other Criteria:

G. Myasthenia gravis (MG) AND ONE of the following:

i. Patient is in acute myasthenic crisis OR

ii. Patient has severe refractory MG (e.g., major functional disability/weakness) AND ONE of the following:

a) Patient has failed ONE immunomodulator therapy (i.e., corticosteroid, pyridostigmine, or azathioprine) OR

b) Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE immunomodulator therapy OR

H. Multiple sclerosis (MS) AND BOTH of the following:

i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND

ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication to TWO MS agents (e.g., Avonex, Betaseron, Copaxone, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Mayzent, Plegridy, teriflunomide, Vumerity) OR

I. Acquired von Willebrand hemophilia AND ONE of the following:

i. Patient has failed ONE conventional therapy (e.g., desmopressin solution, von Willebrand factor replacement therapy, corticosteroids, cyclophosphamide, FEIBA, or recombinant factor VIIa) OR

ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

J. Refractory pemphigus vulgaris AND ONE of the following:

i. Patient has failed ONE conventional immunosuppressive therapy (e.g., azathioprine, cyclophosphamide, mycophenolate, corticosteroids) OR

ii. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional immunosuppressive therapy OR

2. ONE of the following:

A. Patient has another FDA labeled indication for the requested agent OR

B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Indications with 6 months approval duration: Acquired von Willebrand hemophilia, Guillain-Barre Syndrome, Lambert-Eaton myasthenia syndrome, Kawasaki disease, CMV induced pneumonitis in solid organ transplant, Toxic shock syndrome due to invasive group A streptococcus, Toxic epidermal necrolysis and Stevens-Johnson syndrome

Drug is also subject to Part B versus Part D review.

Prior Authorization Group Description:
Pegylated Interferon PA
Drug Name(s)
Pegasys
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic hepatitis B AND BOTH of the following:
        i. The chronic hepatitis B infection has been confirmed by serological markers AND
        ii. Patient has NOT been administered the requested agent for more than 48 weeks for the treatment of chronic hepatitis B OR
    B. BOTH of the following:
        i. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND
        ii. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype OR
    C. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
12 months for all other diagnoses. For hep B, hep C see Other Criteria
Other Criteria:
No prior peginterferon alfa use, approve 48 weeks for hepatitis B infection. Prior peginterferon alfa use, approve remainder of 48 weeks of total therapy for hepatitis B infection

Duration of therapy for hepatitis C: Based on FDA approved labeling or AASLD/IDSA guideline supported

Prior Authorization Group Description:
Pirfenidone PA
Drug Name(s)
Esbriet
Pirfenidone
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF) AND
2. Patient has no known explanation for interstitial lung disease (ILD) or pulmonary fibrosis (e.g., radiation, drugs, metal dusts, sarcoidosis, or any connective tissue disease known to cause ILD)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF) AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., pathologist, pulmonologist, radiologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Posaconazole PA
Drug Name(s)
Noxafil
Posaconazole Inj
Posaconazole Dr
Posaconazole Susp
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of oropharyngeal candidiasis AND ONE of the following:
        i. Patient has tried and had an inadequate response to fluconazole or an alternative antifungal agent OR
        ii. Patient has an intolerance or hypersensitivity to fluconazole or an alternative antifungal agent OR
        iii. Patient has an FDA labeled contraindication to fluconazole or an alternative antifungal agent OR
    B. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida AND patient is severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR
    C. Patient has a diagnosis of invasive Aspergillus AND ONE of the following:
        i. Patient has tried and had an inadequate response to an alternative antifungal agent OR
        ii. Patient has an intolerance or hypersensitivity to an alternative antifungal agent OR
        iii. Patient has an FDA labeled contraindication to an alternative antifungal agent OR
    D. Patient has another indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
One month for oropharyngeal candidiasis, 6 months for all other indications
Other Criteria:
Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND

2. ONE of the following:

A. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida and patient continues to be severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR

B. Patient has a diagnosis of invasive Aspergillus AND patient has continued indicators of active disease (e.g., continued radiologic findings, positive cultures, positive serum galactomannan assay for Aspergillus) OR

C. BOTH of the following:

i. Patient has a diagnosis of oropharyngeal candidiasis AND

ii. Patient has had clinical benefit with the requested agent OR

D. BOTH of the following:

i. Patient has another indication that is supported in CMS approved compendia for the requested agent AND

ii. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Praluent PA
Drug Name(s)
Praluent
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has ONE of the following:
    A. A diagnosis of heterozygous familial hypercholesterolemia (HeFH) AND ONE of the following:
        i. Genetic confirmation of one mutant allele at the LDLR, Apo-B, PCSK9, or 1/LDLRAP1 gene OR
        ii. History of LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) (pretreatment) OR
        iii. Patient has clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthoma, or xanthelasma) OR
        iv. Patient has “definite” or “possible” familial hypercholesterolemia as defined by the Simon Broome criteria OR
        v. Patient has a Dutch Lipid Clinic Network criteria score of greater than 5 OR
        vi. Patient has a treated low-density lipoprotein cholesterol (LDL-C) level 100 mg/dL or greater after treatment with antihyperlipidemic agents but prior to PCSK9 inhibitor therapy OR
    B. A diagnosis of homozygous familial hypercholesterolemia (HoFH) AND ONE of the following:
        i. Genetic confirmation of two mutant alleles at the LDLR, Apo-B, PCSK9, or LDLRAP1 gene OR
        ii. History of untreated LDL-C greater than 500 mg/dL (greater than 13 mmol/L) or treated LDL-C 300 mg/dL or greater (7.76 mmol/L or greater) OR
        iii. Patient has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma) OR
    C. A diagnosis of established cardiovascular disease [angina pectoris, coronary heart disease, myocardial infarction, transient ischemic attacks, cerebrovascular disease (CeVD) or peripheral vascular disease (PVD) or after coronary revascularization or carotid endarterectomy] AND the requested agent will be used to reduce the risk of myocardial infarction, stroke, and unstable angina OR
    D. A diagnosis of primary hyperlipidemia (not associated with HeFH, HoFH, or established cardiovascular disease) OR

Initial criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
The agent was prescribed by, or in consultation with, a cardiologist, an endocrinologist, and/or a physician who focuses in the treatment of cardiovascular (CV) risk management and/or lipid disorders
Coverage Duration:

Approval will be for 12 months

Other Criteria:

E. Patient has another indication that is supported in CMS approved compendia for the requested agent AND

2. ONE of the following:

A. Patient has tried and had an inadequate response to a high-intensity statin (i.e., rosuvastatin 20-40 mg or atorvastatin 40-80 mg) OR

B. Patient has an intolerance to TWO different statins OR

C. Patient has an FDA labeled contraindication to a statin AND

3. Patient will NOT be using the requested agent in combination with another PCSK9 agent AND

4. ONE of the following:

A. Patient has tried and had an inadequate response to Repatha OR

B. Patient has an intolerance or hypersensitivity to Repatha OR

C. Patient has an FDA labeled contraindication to Repatha

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND

2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND

3. Patient has had clinical benefit with the requested agent AND

4. Patient will NOT be using the requested agent in combination with another PCSK9 agent

Prior Authorization Group Description:
Prolia PA
Drug Name(s)
Prolia
Indications:
All FDA-Approved Indications, Some Medically-Accepted Indications.
Off-Label Uses:
Osteopenia (osteoporosis prophylaxis)
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of:
1. ONE of:
    A. Patient's (pt) sex is male or the pt is postmenopausal with a diagnosis of osteoporosis AND BOTH of:
        i. Pt's diagnosis was confirmed by ONE of:
            1. A fragility fracture in the hip or spine OR
            2. A T-score of -2.5 or lower OR
            3. A T-score of -1.0 to -2.5 AND ONE of:
                a. A fragility fracture of the proximal humerus, pelvis, or distal forearm OR
                b. A FRAX 10-year probability for major osteoporotic fracture of 20% or greater OR
                c. A FRAX 10-year probability of hip fracture of 3% or greater AND
        ii. ONE of:
            1. Pt is at a very high fracture risk as defined by ONE of:
                a. Pt had a recent fracture (within the past 12 months) OR
                b. Pt had fractures while on FDA approved osteoporosis therapy OR
                c. Pt has had multiple fractures OR
                d. Pt had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR
                e. Pt has a very low T-score (less than -3.0) OR
                f. Pt is at high risk for falls or has a history of injurious falls OR
                g. Pt has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm OR
            2. ONE of:
                a. Pt's medication history includes use of a bisphosphonate OR
                b. Pt has an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate OR
    B. Pt is requesting the agent for osteopenia (osteoporosis prophylaxis) AND ALL of:
        i. ONE of:
            1. Pt's sex is male and the pt is 50 years of age or over OR
            2. Pt is postmenopausal AND

ii. Pt has a T-score between -1.0 to -2.50 AND
iii. ONE of:
a. A fragility fracture of the proximal humerus, pelvis, or distal forearm OR
b. 10-year probability of a hip fracture 3% and greater per FRAX OR
c. 10-year probability of a major OP-related fracture 20% and greater per FRAX AND
iv. ONE of:
a. Pt's medication history includes use of a bisphosphonate OR

Criteria continues: See Other Criteria
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
b. Pt has an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate OR

C. Pt's sex is a female with a diagnosis of breast cancer who is receiving aromatase inhibitor therapy AND ONE of:
i. Pt's medication history includes use of a bisphosphonate OR
ii. Pt has an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate OR

D. Pt's sex is male with a diagnosis of prostate cancer receiving androgen deprivation therapy (ADT) AND ONE of:
i. Pt's medication history includes use of a bisphosphonate OR
ii. Pt has an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate OR

E. Pt has a diagnosis of glucocorticoid-induced osteoporosis AND ALL of:
i. Pt is either initiating or continuing systemic glucocorticoids in a daily dose equivalent to 7.5 mg or greater of prednisone AND
ii. Pt is expected to remain on glucocorticoids for at least 6 months AND
iii. Pt's diagnosis was confirmed by ONE of:
1. A fragility fracture in the hip or spine OR
2. A T-score of -2.5 or lower OR
3. A T-score of -1.0 to -2.5 AND ONE of the following:
a. A fragility fracture of the proximal humerus, pelvis, or distal forearm OR
b. A FRAX 10-year probability for major osteoporotic fracture of 20% or greater OR
c. A FRAX 10-year probability of hip fracture of 3% or greater AND
iv. ONE of:
1. Pt is at a very high fracture risk as defined by ONE of the following:
a. Pt had a recent fracture (within the past 12 months) OR
b. Pt had fractures while on FDA approved osteoporosis therapy OR

c. Pt has had multiple fractures OR
d. Pt had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR
e. Pt has a very low T-score (less than -3.0) OR
f. Pt is at high risk for falls or has a history of injurious falls OR
g. Pt has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm OR

2. ONE of:
a. Pt's medication history includes use of a bisphosphonate OR
b. Pt has an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate AND

2. ONE of:
A. Pt has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR
B. Pt has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR
C. Prescriber has indicated that the pt is not at risk for hypocalcemia (not including risk associated with the requested agent) AND

3. Pt will NOT be using the requested agent in combination with a bisphosphonate, another form of denosumab (e.g., Xgeva), romosozumab-aqqg, or parathyroid hormone analog (e.g., abaloparatide, teriparatide) for the requested indication AND

4. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Prior Authorization Group Description:

Promacta PA

Drug Name(s)

Promacta

Indications:

All Medically-Accepted Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Criteria for initial approval require ONE of the following:

1. Patient (pt) has a diagnosis of persistent or chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following:
    - A. Pt has tried and had an insufficient response to a corticosteroid or immunoglobulin (IVIg or anti-D) OR
    - B. Pt has an intolerance or hypersensitivity to a corticosteroid or immunoglobulin (IVIg or anti-D) OR
    - C. Pt has an FDA labeled contraindication to a corticosteroid or immunoglobulin (IVIg or anti-D) OR
    - D. Pt has had an insufficient response to a splenectomy OR
2. Pt has a diagnosis of hepatitis C associated thrombocytopenia AND ONE of the following:
    - A. Pt's platelet count is less than 75 x 10^9/L AND the intent is to increase platelet counts sufficiently to initiate pegylated interferon therapy OR
    - B. Pt is on concurrent therapy with a pegylated interferon and ribavirin AND is at risk for discontinuing hepatitis C therapy due to thrombocytopenia OR
3. Pt has a diagnosis of severe aplastic anemia (SAA) AND ALL of the following:
    - A. Pt has at least 2 of the following blood criteria:
        - i. Neutrophils less than 0.5 X 10^9/L OR
        - ii. Platelets less than 30 X 10^9/L OR
        - iii. Reticulocyte count less than 60 X 10^9/L AND
    - B. Pt has at least 1 of the following marrow criteria:
        - i. Severe hypocellularity is less than 25% OR
        - ii. Moderate hypocellularity is 25-50% with hematopoietic cells representing less than 30% of residual cells AND
    - C. ONE of the following:
        - i. Pt has tried and had an insufficient response to BOTH antithymocyte globulin (ATG) AND cyclosporine therapy OR
        - ii. BOTH of the following:
            1. Pt will be using the requested agent as first-line treatment (i.e., has not been treated with ATG and/or cyclosporine) AND
            2. Pt will use the requested agent in combination with standard immunosuppressive therapy (i.e., ATG AND cyclosporine) OR
4. Pt has another indication that is supported in CMS approved compendia for the requested agent

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Initial: 6 months for ITP. Renewal: 12 months for ITP. Other indications, see Other Criteria.

Other Criteria:

Criteria for renewal approval require BOTH of the following:
1. Pt has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Pt has a diagnosis of persistent or chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following:
        i. Pt's platelet count is 50 x 10^9/L or greater OR
        ii. Pt's platelet count has increased sufficiently to avoid clinically significant bleeding OR
    B. Pt has a diagnosis of hepatitis C associated thrombocytopenia AND BOTH of the following:
        i. ONE of the following:
            1. Pt will be initiating hepatitis C therapy with pegylated interferon and ribavirin OR
            2. Pt will be maintaining hepatitis C therapy with pegylated interferon and ribavirin at the same time as the requested agent AND
        ii. ONE of the following:
            1. Pt's platelet count is 90 x 10^9/L or greater OR
            2. Pt's platelet count has increased sufficiently to initiate or maintain pegylated interferon based therapy for the treatment of hepatitis C OR
    C. Pt has a diagnosis of severe aplastic anemia (SAA) AND the pt has had clinical benefit with the requested agent OR
    D. Pt has another indication that is supported in CMS approved compendia and the pt has had clinical benefit with the requested agent

Initial: 48 weeks for hepatitis C associated thrombocytopenia, 6 months for first-line therapy in severe aplastic anemia, 16 weeks for SAA, 12 months for All other indications

Renewal: 48 weeks for hepatitis C associated thrombocytopenia, 12 months for SAA, 12 months for All other indications

Prior Authorization Group Description:
Pulmonary Hypertension PA – Adempas
Drug Name(s)
Adempas
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
            b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND
        ii. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH), WHO Group 4, as determined by a ventilation-perfusion scan and a confirmatory selective pulmonary angiography AND ALL of the following:
        i. ONE of the following:
            a. Patient is NOT a candidate for surgery OR
            b. Patient has had pulmonary endarterectomy AND has persistent or recurrent disease AND
        ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND
        iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND
        iv. Patient has a pulmonary vascular resistance greater than or equal to 3 Wood units OR
    C. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following:
        i. Patient's World Health Organization (WHO) functional class is II or greater AND
        ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND
        iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND
        iv. Patient has a pulmonary vascular resistance greater than or equal to 3 Wood units AND

Initial criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:

v. ONE of the following:

a. The requested agent will be utilized as monotherapy OR

b. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), AND BOTH of the following:

1. Patient has unacceptable or deteriorating clinical status despite established pharmacotherapy AND

2. The requested agent is in a different therapeutic class OR

c. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND ALL of the following:

1. ONE of the following:

i. A prostanoid has been started as one of the agents in the triple therapy OR

ii. Patient has an intolerance or hypersensitivity to a prostanoid OR

iii. Patient has an FDA labeled contraindication to a prostanoid AND

2. Patient has unacceptable or deteriorating clinical status despite established pharmacotherapy AND

3. All three agents in the triple therapy are from a different therapeutic class

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND

2. Patient has an FDA labeled indication for the requested agent AND

3. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Pulmonary Hypertension PA – Ambrisentan
Drug Name(s)
Ambrisentan
Letairis
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND
ii. Patient has an FDA labeled indication for the requested agent OR
B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following:
i. Patient's World Health Organization (WHO) functional class is II or greater AND
ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND
iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND
iv. Patient has a pulmonary vascular resistance greater than or equal to 3 Wood units AND
v. ONE of the following:
a. The requested agent will be utilized as monotherapy OR
b. The requested agent will be used in combination with a phosphodiesterase 5 (PDE5) inhibitor for dual therapy ONLY OR
c. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), [except for dual therapy requests for a phosphodiesterase 5 (PDE 5) inhibitor plus an endothelin receptor antagonist (ERA)], AND BOTH of the following:
1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
2. The requested agent is in a different therapeutic class OR

Initial criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 12 months

Other Criteria:

d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND ALL of the following:

1. ONE of the following:

i. A prostanoid has been started as one of the agents in the triple therapy OR

ii. Patient has an intolerance or hypersensitivity to a prostanoid OR

iii. Patient has an FDA labeled contraindication to a prostanoid AND

2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND

3. All three agents in the triple therapy are from a different therapeutic class

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Pulmonary Hypertension PA – Bosentan
Drug Name(s)
Bosentan
Tracleer
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Elevated liver enzymes accompanied by signs or symptoms of liver dysfunction/injury or a bilirubin level of 2 times the ULN (upper limit of normal) or greater AND FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
            b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1, as determined by right heart catheterization, AND ALL of the following:
        i. Patient's World Health Organization (WHO) functional class is II or greater AND
        ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND
        iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND
        iv. Patient has a pulmonary vascular resistance greater than or equal to 3 Wood units AND
        v. ONE of the following:
            a. The requested agent will be utilized as monotherapy OR
            b. The requested agent will be used in combination with a phosphodiesterase 5 (PDE5) inhibitor for dual therapy ONLY OR
            c. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), [except for dual therapy requests for a phosphodiesterase 5 inhibitor (PDE5) plus an endothelin receptor antagonist (ERA)], AND BOTH of the following:
                1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
                2. The requested agent is in a different therapeutic class OR

Initial criteria continues: see Other Criteria

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND ALL of the following:

1. ONE of the following:

i. A prostanoid has been started as one of the agents in the triple therapy OR

ii. Patient has an intolerance or hypersensitivity to a prostanoid OR

iii. Patient has an FDA labeled contraindication to a prostanoid AND

2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND

3. All three agents in the triple therapy are from a different therapeutic class OR

C. Patient has an indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Pulmonary Hypertension PA – Opsumit
Drug Name(s)
Opsumit
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
            b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND
        ii. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following:
        i. Patient's World Health Organization (WHO) functional class is II or greater AND
        ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND
        iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND
        iv. Patient has a pulmonary vascular resistance greater than or equal to 3 Wood units AND
        v. ONE of the following:
            a. The requested agent will be utilized as monotherapy OR
            b. The requested agent will be used in combination with a phosphodiesterase 5 (PDE5) inhibitor for dual therapy ONLY OR
            c. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), [except for dual therapy requests for a phosphodiesterase 5 (PDE 5) inhibitor plus an endothelin receptor antagonist (ERA)], AND BOTH of the following:
                1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
                2. The requested agent is in a different therapeutic class OR

Initial criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:

d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND ALL of the following:

1. ONE of the following:

i. A prostanoid has been started as one of the agents in the triple therapy OR

ii. Patient has an intolerance or hypersensitivity to a prostanoid OR

iii. Patient has an FDA labeled contraindication to a prostanoid AND

2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND

3. All three agents in the triple therapy are from a different therapeutic class

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Pulmonary Hypertension PA – Orenitram
Drug Name(s)
Orenitram
Orenitram Titration Kit Month 1
Orenitram Titration Kit Month 2
Orenitram Titration Kit Month 3
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
            b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND
        ii. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following:
        i. Patient's World Health Organization (WHO) functional class is II or greater AND
        ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND
        iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND
        iv. Patient has a pulmonary vascular resistance greater than or equal to 3 Wood units AND
        v. ONE of the following:
            a. The requested agent will be utilized as monotherapy OR
            b. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), AND BOTH of the following:
                1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
                2. The requested agent is in a different therapeutic class OR
            c. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND ALL of the following:
                1. Patient is WHO functional class III or IV AND
                2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND

3. All three agents in the triple therapy are from a different therapeutic class

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Pulmonary Hypertension PA – Sildenafil
Drug Name(s)
Liqrev
Revatio
Sildenafil
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Concurrently taking another phosphodiesterase 5 (PDE 5) inhibitor with the requested agent AND FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
            b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following:
        i. Patient's World Health Organization (WHO) functional class is II or greater AND
        ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND
        iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND
        iv. Patient has a pulmonary vascular resistance greater than or equal to 3 Wood units AND
        v. ONE of the following:
            a. The requested agent will be utilized as monotherapy OR
            b. The requested agent will be used in combination with an endothelin receptor antagonist (ERA) for dual therapy ONLY OR
            c. The requested agent will be utilized for add-on therapy to existing monotherapy, [except for dual requests for a phosphodiesterase 5 (PDE5) inhibitor plus an endothelin receptor antagonist (ERA)], AND BOTH of the following:
                1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
                2. The requested agent is in a different therapeutic class OR

Initial criteria continues: see Other Criteria

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy) AND ALL of the following:

1. ONE of the following:

i. A prostanoid has been started as one of the agents in the triple therapy OR

ii. Patient has an intolerance or hypersensitivity to a prostanoid OR

iii. Patient has an FDA labeled contraindication to a prostanoid AND

2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND

3. All three agents in the triple therapy are from a different therapeutic class OR

C. Patient has an indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Pulmonary Hypertension PA – Tadalafil
Drug Name(s)
Adcirca
Alyq
Tadalafil 20Mg Tablet
Tadliq
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Concurrently taking another phosphodiesterase 5 (PDE 5) inhibitor with the requested agent AND FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
            b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following:
        i. Patient's World Health Organization (WHO) functional class is II or greater AND
        ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND
        iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND
        iv. Patient has a pulmonary vascular resistance greater than or equal to 3 Wood units AND
        v. ONE of the following:
            a. The requested agent will be utilized as monotherapy OR
            b. The requested agent will be used in combination with an endothelin receptor antagonist (ERA) for dual therapy ONLY OR
            c. The requested agent will be utilized for add-on therapy to existing monotherapy, [except for dual requests for a phosphodiesterase 5 (PDE5) inhibitor plus an endothelin receptor antagonist (ERA)], AND BOTH of the following:
                1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
                2. The requested agent is in a different therapeutic class OR

Initial criteria continues: see Other Criteria

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy) AND ALL of the following:

1. ONE of the following:

i. A prostanoid has been started as one of the agents in the triple therapy OR

ii. Patient has an intolerance or hypersensitivity to a prostanoid OR

iii. Patient has an FDA labeled contraindication to a prostanoid AND

2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND

3. All three agents in the triple therapy are from a different therapeutic class OR

C. Patient has an indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND

2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND

3. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Pulmonary Hypertension PA – Tyvaso DPI
Drug Name(s)
Tyvaso DPI Maintenance Kit
Tyvaso DPI Titration Kit
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
            b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND
        ii. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following:
        i. Patient's World Health Organization (WHO) functional class is II or greater AND
        ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND
        iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND
        iv. Patient has a pulmonary vascular resistance greater than or equal to 3 Wood units AND
        v. ONE of the following:
            a. The requested agent will be utilized as monotherapy OR
            b. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), AND BOTH of the following:
                1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
                2. The requested agent is in a different therapeutic class OR
            c. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND ALL of the following:
                1. Patient is WHO functional class III or IV AND
                2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
                3. All three agents in the triple therapy are from a different therapeutic class OR

Initial criteria continues: see Other Criteria

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

C. Patient has a diagnosis of pulmonary hypertension associated with interstitial lung disease (PH-ILD, WHO group 3) as determined by right heart catheterization AND ALL of the following:

i. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND
ii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND
iii. Patient has a pulmonary vascular resistance greater than or equal to 3 Wood units AND
iv. Patient has a forced vital capacity (FVC) less than 70% of predicted AND
v. Patient will continue standard of care therapy for ILD (e.g., nintedanib)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. ONE of the following:

A. Patient has a diagnosis of pulmonary hypertension associated with interstitial lung disease (PH-ILD, WHO group 3) AND the patient will continue standard of care therapy for ILD (e.g., nintedanib) OR
B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1

Prior Authorization Group Description:
Pulmonary Hypertension PA – Uptravi
Drug Name(s)
Uptravi
Uptravi Titration Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
            b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND
        ii. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following:
        i. Patient's World Health Organization (WHO) functional class is II or greater AND
        ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND
        iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND
        iv. Patient has a pulmonary vascular resistance greater than or equal to 3 Wood units AND
        v. ONE of the following:
            a. The requested agent will be utilized as monotherapy OR
            b. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), AND BOTH of the following:
                1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
                2. The requested agent is in a different therapeutic class OR
            c. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND BOTH of the following:
                1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
                2. All three agents in the triple therapy are from a different therapeutic class

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Pulmonary Hypertension PA – Ventavis
Drug Name(s)
Ventavis
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
            b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND
        ii. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following:
        i. Patient's World Health Organization (WHO) functional class is II or greater AND
        ii. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND
        iii. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND
        iv. Patient has a pulmonary vascular resistance greater than or equal to 3 Wood units AND
        v. ONE of the following:
            a. The requested agent will be utilized as monotherapy OR
            b. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), AND BOTH of the following:
                1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
                2. The requested agent is in a different therapeutic class OR
            c. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND ALL of the following:
                1. Patient is WHO functional class III or IV AND
                2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
                3. All three agents in the triple therapy are from a different therapeutic class
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

Approval will be for 12 months

Other Criteria:

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent

Drug is also subject to Part B versus Part D review.

Prior Authorization Group Description:
Pyrimethamine PA
Drug Name(s)
Pyrimethamine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 6 months
Other Criteria:

Prior Authorization Group Description:
Pyrukynd PA
Drug Name(s)
Pyrukynd
Pyrukynd Taper Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require the following:
1. Patient has a diagnosis of hemolytic anemia with pyruvate kinase deficiency (PKD)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of hemolytic anemia with pyruvate kinase deficiency (PKD) AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., hematologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Qbrexza PA
Drug Name(s)
Qbrexza
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has a diagnosis of primary axillary hyperhidrosis
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Quillichew PA
Drug Name(s)
Quillichew Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Quillivant PA
Drug Name(s)
Quillivant Xr
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Quinine PA
Drug Name(s)
Qualaquin
Quinine Sulfate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has ONE of the following diagnoses:
    a. Uncomplicated malaria OR
    b. Babesiosis OR
    c. An indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
7 days for malaria, 10 days for babesiosis, 12 months for all other diagnoses
Other Criteria:

Prior Authorization Group Description:
Qulipta PA
Drug Name(s)
Qulipta
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of migraine AND
2. The requested agent is being used for migraine prophylaxis AND
3. Patient has 4 migraine headaches or more per month AND
4. ONE of the following:
    A. Patient has tried and had an inadequate response to a conventional migraine prophylaxis agent [e.g., beta blockers (propranolol), anticonvulsants (divalproex, topiramate)] OR
    B. Patient has an intolerance, or hypersensitivity to a conventional migraine prophylaxis agent OR
    C. Patient has an FDA labeled contraindication to a conventional migraine prophylaxis agent AND
5. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of migraine AND
3. The requested agent is being used for migraine prophylaxis AND
4. Patient has had clinical benefit with the requested agent AND
5. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Quviviq PA
Drug Name(s)
Quviviq
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Radicava PA
Drug Name(s)
Radicava
Radicava Ors
Radicava Ors Starter Kit
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of amyotrophic lateral sclerosis (ALS) [also known as Lou Gehrig's disease] AND
2. ALL of the following:
    A. Patient is able to perform most activities of daily living AND
    B. Patient has had the diagnosis of amyotrophic lateral sclerosis (ALS) for a duration of 2 years or less AND
    C. Patient has a baseline percent predicted forced vital capacity (FVC) of 80% or greater AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of amyotrophic lateral sclerosis (ALS) [also known as Lou Gehrig's disease] AND
3. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal
Other Criteria:

Prior Authorization Group Description:
Rasuvo PA
Drug Name(s)
Rasuvo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to a generic methotrexate injectable agent OR
    B. Patient has an intolerance or hypersensitivity to a generic methotrexate injectable agent OR
    C. Patient has an FDA labeled contraindication to a generic methotrexate injectable agent OR
    D. Prescriber has provided information that the patient has a physical or a mental disability that would prevent the patient from using a generic methotrexate injectable agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:

Rayos PA

Drug Name(s)

Rayos

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

Required Medical Information:

Criteria for approval require BOTH of the following:

1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    a. Patient has tried and failed generic oral prednisone AND at least 1 other different generic oral corticosteroid agent (e.g., dexamethasone, methylprednisolone) OR
    b. Patient has an intolerance or hypersensitivity to generic oral prednisone AND at least 1 other different generic oral corticosteroid agent (e.g., dexamethasone, methylprednisolone) OR
    c. Patient has an FDA labeled contraindication to generic oral prednisone AND at least 1 other different generic oral corticosteroid agent (e.g., dexamethasone, methylprednisolone)

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 6 months

Other Criteria:

Prior Authorization Group Description:
Reblozyl PA
Drug Name(s)
Reblozyl
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. BOTH of the following:
        i. Patient has a diagnosis of Beta thalassemia requiring regular red blood cell (RBC) transfusions AND
        ii. Patient's diagnosis was confirmed by BOTH of the following:
            a. Hemoglobin analysis by hemoglobin electrophoresis or high-performance liquid chromatography AND
            b. Genetic analysis for both Beta thalassemia and Alpha thalassemia mutations OR
    B. Patient has a diagnosis of anemia associated with myelodysplastic syndrome with ring sideroblasts (MDS-RS) AND BOTH of the following:
        i. Patient has very low-to-intermediate-risk disease AND
        ii. BOTH of the following:
            a. Patient has tried and had an inadequate response to an erythropoiesis stimulating agent (ESA) [e.g., Aranesp (darbepoetin alfa), Epogen/Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)] AND
            b. Patient has required 2 or more red blood cell (RBC) units over 8 weeks OR
    C. Patient has a diagnosis of anemia associated with myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T) AND BOTH of the following:
        i. Patient has very low-to-intermediate-risk disease AND
        ii. BOTH of the following:
            a. Patient has tried and had an inadequate response to an erythropoiesis stimulating agent (ESA) [e.g., Aranesp (darbepoetin alfa), Epogen/Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)] AND
            b. Patient has required 2 or more red blood cell (RBC) units over 8 weeks OR
    D. Patient has a diagnosis of anemia associated with myelodysplastic syndromes (MDS) without previous erythropoiesis stimulating agent use (ESA-naive) AND BOTH of the following:
        i. Patient has very low-to-intermediate-risk disease AND
        ii. Patient has required 2 or more red blood cell (RBC) units over 8 weeks AND
2. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., hematologist, oncologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Initial approval: 15 wks for Beta thalassemia, 12 mos for all other diagnoses. 12 mos for renewal.

Other Criteria:

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of Beta thalassemia requiring regular red blood cell (RBC) transfusions OR
    B. Patient has a diagnosis of anemia associated with myelodysplastic syndrome with ring sideroblasts (MDS-RS) OR
    C. Patient has a diagnosis of anemia associated with myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T) OR
    D. Patient has a diagnosis of anemia associated with myelodysplastic syndromes (MDS) without previous erythropoiesis stimulating agent use (ESA-naive) AND
3. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing for the requested indication

Prior Authorization Group Description:
Recorlev PA
Drug Name(s)
Recorlev
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of endogenous hypercortisolemia with Cushing's syndrome AND
2. ONE of the following:
    A. Patient had an inadequate response to pituitary surgical resection OR
    B. Patient is NOT a candidate for pituitary surgical resection AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to pasireotide OR
    B. Patient has an intolerance or hypersensitivity to pasireotide OR
    C. Patient has an FDA labeled contraindication to pasireotide

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of endogenous hypercortisolemia with Cushing's syndrome AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Reditrex PA
Drug Name(s)
Reditrex
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to a generic methotrexate injectable agent OR
    B. Patient has an intolerance or hypersensitivity to a generic methotrexate injectable agent OR
    C. Patient has an FDA labeled contraindication to a generic methotrexate injectable agent OR
    D. Prescriber has provided information that the patient has a physical or a mental disability that would prevent the patient from using a generic methotrexate injectable agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Regranex PA
Drug Name(s)
Regranex
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    a. BOTH of the following:
        i. Patient has a diagnosis of lower extremity diabetic neuropathic ulcer(s) that extends into the subcutaneous tissue or beyond AND
        ii. The ulcer(s) intended for treatment has an adequate blood supply OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Relexxii PA
Drug Name(s)
Methylphenidate Hydrochloride Er (Relexxii)
Relexxii
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Relistor Inj PA
Drug Name(s)
Relistor Inj
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. ONE of the following diagnoses:
    A. Patient has opioid-induced constipation (OIC) with advanced illness or pain caused by active cancer and is receiving palliative care OR
    B. Patient has opioid induced constipation (OIC) and chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment AND
2. Patient has chronic use of an opioid agent in the past 90 days AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to lactulose OR
    B. Patient has an intolerance or hypersensitivity to lactulose OR
    C. Patient has an FDA labeled contraindication to lactulose
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Relistor Tablet PA
Drug Name(s)
Relistor Tab
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has opioid induced constipation (OIC) and chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment AND
2. Patient has chronic use of an opioid agent in the past 90 days AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to lactulose OR
    B. Patient has an intolerance or hypersensitivity to lactulose OR
    C. Patient has an FDA labeled contraindication to lactulose
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Relyvrio PA
Drug Name(s)
Relyvrio
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of amyotrophic lateral sclerosis (ALS) [also known as Lou Gehrig's disease] AND
2. BOTH of the following:
    A. Patient's symptom onset was within the past 18 months AND
    B. Patient has a baseline percent predicted forced vital capacity (FVC) or slow vital capacity (SVC) greater than 60%

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of amyotrophic lateral sclerosis (ALS) [also known as Lou Gehrig's disease] AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Repatha PA
Drug Name(s)
Repatha
Repatha Pushtronex System
Repatha Sureclick
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has ONE of the following:
    A. A diagnosis of heterozygous familial hypercholesterolemia (HeFH) AND ONE of the following:
        i. Genetic confirmation of one mutant allele at the LDLR, Apo-B, PCSK9, or 1/LDLRAP1 gene OR
        ii. History of LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) (pretreatment) OR
        iii. Patient has clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthoma, or xanthelasma) OR
        iv. Patient has “definite” or “possible” familial hypercholesterolemia as defined by the Simon Broome criteria OR
        v. Patient has a Dutch Lipid Clinic Network criteria score of greater than 5 OR
        vi. Patient has a treated low-density lipoprotein cholesterol (LDL-C) level 100 mg/dL or greater after treatment with antihyperlipidemic agents but prior to PCSK9 inhibitor therapy OR
    B. A diagnosis of homozygous familial hypercholesterolemia (HoFH) AND ONE of the following:
        i. Genetic confirmation of two mutant alleles at the LDLR, Apo-B, PCSK9, or LDLRAP1 gene OR
        ii. History of untreated LDL-C greater than 500 mg/dL (greater than 13 mmol/L) or treated LDL-C 300 mg/dL or greater (7.76 mmol/L or greater) OR
        iii. Patient has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma) OR
    C. A diagnosis of established cardiovascular disease [angina pectoris, coronary heart disease, myocardial infarction, transient ischemic attacks, cerebrovascular disease (CeVD) or peripheral vascular disease (PVD) or after coronary revascularization or carotid endarterectomy] AND the requested agent will be used to reduce the risk of myocardial infarction, stroke, and coronary revascularization OR
    D. A diagnosis of primary hyperlipidemia (not associated with HeFH, HoFH, or established cardiovascular disease) OR

Initial criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:

The agent was prescribed by, or in consultation with, a cardiologist, an endocrinologist, and/or a physician who focuses in the treatment of cardiovascular (CV) risk management and/or lipid disorders

Coverage Duration:

Approval will be for 12 months

Other Criteria:

E. Patient has another indication that is supported in CMS approved compendia for the requested agent AND

3. ONE of the following:

A. Patient has tried and had an inadequate response to a high-intensity statin (i.e., rosuvastatin 20-40 mg or atorvastatin 40-80 mg) OR

B. Patient has an intolerance to TWO different statins OR

C. Patient has an FDA labeled contraindication to a statin AND

4. Patient will NOT be using the requested agent in combination with another PCSK9 agent

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND

2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND

3. Patient has had clinical benefit with the requested agent AND

4. Patient will NOT be using the requested agent in combination with another PCSK9 agent

Prior Authorization Group Description:
Reyvow PA
Drug Name(s)
Reyvow
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. The requested agent will be used for the treatment of acute migraine with or without aura AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to TWO triptan agents with differing active ingredients (e.g., sumatriptan, rizatriptan) OR
    B. Patient has an intolerance or hypersensitivity to TWO triptan agents with differing active ingredients OR
    C. Patient has an FDA labeled contraindication to TWO triptan agents with differing active ingredients AND
3. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. The requested agent will be used for the treatment of acute migraine with or without aura AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Ritalin LA PA
Drug Name(s)
Methylphenidate Hydrochloride Er (Ritalin LA)
Ritalin La
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Ritalin PA
Drug Name(s)
Methylphenidate Hydrochloride (Ritalin)
Ritalin
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Roflumilast PA
Drug Name(s)
Daliresp
Roflumilast
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to an agent from two of the following categories:
        i. long-acting beta-2 agonist (LABA) [e.g., salmeterol]
        ii. long-acting muscarinic antagonist (LAMA) [e.g., umeclidinium]
        iii. inhaled corticosteroid (ICS) [e.g., fluticasone] OR
    B. Patient has an intolerance or hypersensitivity to an agent from two of the following categories:
        i. long-acting beta-2 agonist (LABA) [e.g., salmeterol]
        ii. long-acting muscarinic antagonist (LAMA) [e.g., umeclidinium]
        iii. inhaled corticosteroid (ICS) [e.g., fluticasone] OR
    C. Patient has an FDA labeled contraindication to an agent from two of the following categories:
        i. long-acting beta-2 agonist (LABA) [e.g., salmeterol]
        ii. long-acting muscarinic antagonist (LAMA) [e.g., umeclidinium]
        iii. inhaled corticosteroid (ICS) [e.g., fluticasone]
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Rybelsus PA
Drug Name(s)
Rybelsus
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of type 2 diabetes mellitus AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. BOTH of the following:
        i. ONE of the following:
            1. Patient's medication history includes use of an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) within the past 90 days OR
            2. Patient had an ineffective treatment response to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            3. Patient has an intolerance or hypersensitivity to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            4. Patient has an FDA labeled contraindication to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Samsca PA
Drug Name(s)
Samsca
Tolvaptan
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the request agent AND Any underlying liver disease, including cirrhosis
Required Medical Information:
Criteria for approval require ALL of the following:
1. The requested agent was initiated (or re-initiated) in the hospital AND
2. Prior to initiating the requested agent, the patient has or had a diagnosis of clinically significant hypervolemic or euvolemic hyponatremia defined by ONE of the following:
    A. Serum sodium is less than 125 mEq/L OR
    B. Serum sodium is 125 mEq/L or greater AND patient has symptomatic hyponatremia that has resisted correction with fluid restriction AND
3. Medications known to cause hyponatremia have been evaluated and discontinued when appropriate AND
4. Patient has NOT already received 30 days of therapy with the requested agent following the most recent hospitalization for initiation of therapy AND
5. The requested dose is within the FDA labeled dosing for the requested indication (Recommended starting dose is 15 mg once daily. Dosage may be increased at intervals greater than or equal to 24 hours to 30 mg once daily, and to a maximum of 60 mg once daily as needed to raise serum sodium. Do not administer for more than 30 days to minimize the risk of liver injury.)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 30 days
Other Criteria:

Prior Authorization Group Description:
Sapropterin PA
Drug Name(s)
Javygtor
Kuvan
Sapropterin Dihydrochloride
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of phenylketonuria (PKU) AND
2. Prescriber has submitted a baseline blood Phe level measured prior to initiation of therapy with the requested agent, which is above the recommended levels indicated for the patient's age range or condition AND
3. Patient will NOT be using the requested agent in combination with Palynziq (pegvaliase-pqpz) for the requested indication AND
4. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of phenylketonuria (PKU) AND
3. ONE of the following:
    a. Patient's blood Phe levels are being maintained within the acceptable range OR
    b. Patient has had a decrease in blood Phe level from baseline AND
4. Patient will NOT be using the requested agent in combination with Palynziq (pegvaliase-pqpz) for the requested indication AND
5. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., metabolic or genetic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Initial: 2 months if dose is 5 to less than 20 mg/kg/day, 1 month if 20 mg/kg/day Renewal: 12 months
Other Criteria:

Prior Authorization Group Description:
Self - Administered Oncology PA
Drug Name(s)
Abiraterone Acetate
Afinitor
Afinitor Disperz
Akeega
Alecensa
Alunbrig
Augtyro
Ayvakit
Balversa
Besremi
Bexarotene Cap
Bosulif
Braftovi
Brukinsa
Cabometyx
Calquence
Caprelsa
Cometriq
Copiktra
Cotellic
Daurismo
Erivedge
Erleada
Erlotinib Hydrochloride
Everolimus
Exkivity
Farydak
Fotivda
Fruzaqla
Gavreto
Gefitinib
Gilotrif
Gleevec
Ibrance
Iclusig
Idhifa
Iwilfin
Imatinib Mesylate
Imbruvica
Inlyta
Inqovi

Inrebic
Iressa
Jakafi
Jaypirca
Kisqali
Kisqali Femara 200 Dose
Kisqali Femara 400 Dose
Kisqali Femara 600 Dose
Koselugo
Krazati
Lapatinib Ditosylate
Lenalidomide
Lenvima 10 Mg Daily Dose
Lenvima 12Mg Daily Dose
Lenvima 14 Mg Daily Dose
Lenvima 18 Mg Daily Dose
Lenvima 20 Mg Daily Dose
Lenvima 24 Mg Daily Dose
Lenvima 4 Mg Daily Dose
Lenvima 8 Mg Daily Dose
Lonsurf
Lorbrena
Lumakras
Lynparza
Lytgobi
Matulane
Mekinist
Mektovi
Nerlynx
Nexavar
Ninlaro
Nubeqa
Odomzo
Ogsiveo
Ojjaara
Onureg
Orgovyx
Orserdu
Pazopanib
Pemazyre
Piqray 200Mg Daily Dose
Piqray 250Mg Daily Dose
Piqray 300Mg Daily Dose
Pomalyst

Qinlock
Retevmo
Revlimid
Rezlidhia
Rozlytrek
Rubraca
Rydapt
Scemblix
Sorafenib
Sprycel
Stivarga
Sunitinib Malate
Sutent
Tabrecta
Tafinlar
Tagrisso
Talzenna
Tarceva
Targretin Cap
Tasigna
Tazverik
Tepmetko
Thalomid
Tibsovo
Tretinoin 10Mg Cap
Truqap
Tukysa
Turalio
Tykerb
Vanflyta
Venclexta
Venclexta Starting Pack
Verzenio
Vitrakvi
Vizimpro
Vonjo
Votrient
Welireg
Xalkori
Xospata
Xpovio
Xpovio 100 Mg Once Weekly
Xpovio 40 Mg Once Weekly
Xpovio 40 Mg Twice Weekly

Xpovio 60 Mg Once Weekly
Xpovio 60 Mg Twice Weekly
Xpovio 80 Mg Once Weekly
Xpovio 80 Mg Twice Weekly
Xtandi
Yonsa
Zejula
Zelboraf
Zolinza
Zydelig
Zykadia
Zytiga

Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. ONE of the following:
            a. The requested agent is FDA labeled or supported by compendia as a first-line therapy for the requested indication OR
            b. Patient has tried appropriate FDA labeled or compendia supported therapy that are indicated as first-line therapy for the requested indication OR
            c. Patient has an intolerance or hypersensitivity to the first-line therapy for the requested indication OR
            d. Patient has an FDA labeled contraindication to the first-line therapy for the requested indication AND
        iv. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines AND

Criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months
Other Criteria:

v. ONE of the following:
    a. The requested agent is not Bosulif or Tasigna OR
    b. The requested agent is Bosulif or Tasigna AND ONE of the following:
        1. Patient's medication history indicates use of imatinib OR Sprycel for the requested indication (if applicable) OR
        2. Patient has an intolerance or hypersensitivity to imatinib OR Sprycel OR
        3. Patient has an FDA labeled contraindication to imatinib OR Sprycel OR
        4. CMS approved compendia does not support the use of imatinib OR Sprycel for the requested indication OR
        5. Prescriber has provided information in support of use of Bosulif or Tasigna over imatinib OR Sprycel for the requested indication AND

vi. ONE of the following:
    a. The requested agent is not Calquence OR
    b. The requested agent is Calquence AND ONE of the following:
        1. Patient's medication history indicates use of Brukinsa OR Imbruvica for the requested indication (if applicable) OR
        2. Patient has an intolerance or hypersensitivity to Brukinsa OR Imbruvica OR
        3. Patient has an FDA labeled contraindication to Brukinsa OR Imbruvica OR
        4. CMS approved compendia do not support the use of Brukinsa OR Imbruvica for the requested indication OR
        5. Prescriber has provided information in support of use of Calquence over Brukinsa OR Imbruvica for the requested indication

Prior Authorization Group Description:
Signifor LAR PA
Drug Name(s)
Signifor Lar
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Severe hepatic impairment (i.e., Child Pugh C)
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of acromegaly AND ONE of the following:
        i. Patient had an inadequate response to surgery as indicated by growth hormone and serum IGF-1 levels that are above the reference ranges for the patient's gender and age OR
        ii. Patient is NOT a candidate for surgery OR
    B. Patient has a diagnosis of Cushing's disease (CD) AND ONE of the following:
        i. Patient had an inadequate response to pituitary surgical resection OR
        ii. Patient is NOT a candidate for pituitary surgical resection OR
    C. Patient has an indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of acromegaly AND ONE of the following:
        i. Patient has growth hormone and serum IGF-1 levels that are within normal limits for patient's gender and age reference range OR
        ii. Patient has had clinical improvement (e.g., reduction in tumor size, decreased headaches, improved cardiovascular or respiratory symptoms) OR
    B. Patient has a diagnosis of Cushing's disease (CD) AND BOTH of the following:
        i. Patient has a urinary free cortisol level less than or equal to the upper limit of normal AND
        ii. Patient has had improvement in at least ONE of the following clinical signs and symptoms:
            1. Fasting plasma glucose OR
            2. Hemoglobin A1c OR
            3. Hypertension OR
            4. Weight OR
    C. BOTH of the following:
        i. Patient has an indication that is supported in CMS approved compendia for the requested agent AND

ii. Patient has had clinical benefit with the requested agent

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Initial: Acromegaly - 6 months, CD - 7 months, All other diagnoses - 12 months, Renewal: 12 months

Other Criteria:

Prior Authorization Group Description:
Signifor PA
Drug Name(s)
Signifor
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Severe hepatic impairment (i.e., Child Pugh C)
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of Cushing's disease (CD) AND ONE of the following:
        i. Patient had an inadequate response to pituitary surgical resection OR
        ii. Patient is NOT a candidate for pituitary surgical resection OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of Cushing's disease (CD) AND BOTH of the following:
        i. Patient has a urinary free cortisol level less than or equal to the upper limit of normal AND
        ii. Patient has had improvement in at least ONE of the following clinical signs and symptoms:
            1. Fasting plasma glucose OR
            2. Hemoglobin A1c OR
            3. Hypertension OR
            4. Weight OR
    B. BOTH of the following:
        i. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Initial approval: 6 months for CD, 12 months for all other diagnoses, Renewal approval: 12 months
Other Criteria:

Prior Authorization Group Description:
Sivextro PA
Drug Name(s)
Sivextro
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following:
    A. BOTH of the following:
        i. A documented acute bacterial skin and skin structure infection (ABSSSI) defined as a bacterial infection of the skin with a lesion size area of at least 75 cm2 (lesion size measured by the area of redness, edema, or induration) AND
        ii. The infection is due to Staphylococcus aureus, Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus anginosus, Streptococcus intermedius, Streptococcus constellatus, or Enterococcus faecalis OR
    B. Another indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. The requested agent is prescribed by an infectious disease specialist or the prescriber has consulted with an infectious disease specialist on treatment of this patient OR
    B. The requested agent is NOT prescribed by an infectious disease specialist or the prescriber has NOT consulted with an infectious disease specialist on treatment of this patient AND ONE of the following:
        i. There is documentation of resistance to TWO of the following: beta-lactams, macrolides, clindamycin, tetracycline, or co-trimoxazole at the site of infection OR
        ii. Patient has an intolerance or hypersensitivity to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR
        iii. Patient has an FDA labeled contraindication to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR
        iv. There is documentation of resistance to vancomycin at the site of infection OR
        v. Patient has an intolerance or hypersensitivity to vancomycin OR
        vi. Patient has an FDA labeled contraindication to vancomycin AND
3. Patient will NOT be using the requested agent in combination with linezolid for the same infection AND
4. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 days for ABSSSI or 30 days for all other indications

Other Criteria:

Prior Authorization Group Description:
Skycarys PA
Drug Name(s)
Skycarys
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require the following:
1. Patient has a diagnosis of Friedreich's ataxia (FA, FRDA) with genetic analysis confirming mutation in the frataxin (FXN) gene

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Friedreich's ataxia (FA, FRDA) AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist, geneticist, neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Sodium Oxybate PA
Drug Name(s)
Sodium Oxybate
Xyrem
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of narcolepsy with cataplexy OR
    B. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness AND BOTH of the following:
        i. ONE of the following:
            a. Patient is under 18 years of age OR
            b. ONE of the following:
                1. Patient has tried and had an inadequate response to modafinil or armodafinil OR
                2. Patient has an intolerance or hypersensitivity to modafinil or armodafinil OR
                3. Patient has an FDA labeled contraindication to modafinil or armodafinil AND
        ii. ONE of the following:
            a. Patient has tried and had an inadequate response to ONE standard stimulant agent (e.g., methylphenidate) OR
            b. Patient has an intolerance or hypersensitivity to ONE standard stimulant agent (e.g., methylphenidate) OR
            c. Patient has an FDA labeled contraindication to ONE standard stimulant agent (e.g., methylphenidate) OR
    C. Patient has another indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Patient is 7 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Somatostatin Analogs PA – Lanreotide
Drug Name(s)
Somatuline Depot
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent OR
    B. ONE of the following:
        i. Patient has a diagnosis of acromegaly AND ONE of the following:
            a. Patient is not a candidate for surgical resection or pituitary radiation therapy OR
            b. The requested agent is for adjunctive therapy with pituitary radiation therapy OR
            c. Patient had an inadequate response to surgery or pituitary radiation therapy as indicated by growth hormone levels or serum IGF-1 levels that are above the reference range OR
        ii. Patient has a diagnosis of gastroenteropancreatic neuroendocrine tumors AND BOTH of the following:
            a. The tumors are well or moderately differentiated AND
            b. ONE of the following:
                1. The tumors are unresectable, locally advanced OR
                2. Patient has metastatic disease OR
        iii. Patient has a diagnosis of carcinoid syndrome OR
        iv. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND

2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. BOTH of the following:
        i. ONE of the following:
            1. Patient has a diagnosis of acromegaly OR
            2. Patient has a diagnosis of metastatic OR unresectable, locally advanced, well or moderately differentiated gastroenteropancreatic neuroendocrine tumors OR
            3. Patient has a diagnosis of carcinoid syndrome OR
            4. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Prior Authorization Group Description:
Somatostatin Analogs PA – Mycapssa
Drug Name(s)
Mycapssa
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    B. ONE of the following:
        i. BOTH of the following:
            a. Patient has a diagnosis of acromegaly AND
            b. Patient has responded to and tolerated treatment with octreotide or lanreotide OR
        ii. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of acromegaly OR
    B. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be 9 months for initial, 12 months for renewal
Other Criteria:

Prior Authorization Group Description:
Somatostatin Analogs PA – Octreotide
Drug Name(s)
Octreotide Acetate
Sandostatin
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    B. ONE of the following:
        i. Patient has a diagnosis of acromegaly AND ONE of the following:
            a. Patient is not a candidate for surgical resection or pituitary radiation therapy OR
            b. The requested agent is for adjunctive therapy with pituitary radiation therapy OR
            c. Patient had an inadequate response to surgery or pituitary radiation therapy as indicated by growth hormone levels or serum IGF-1 levels that are above the reference range OR
        ii. Patient has severe diarrhea and/or flushing episodes associated with metastatic carcinoid tumors OR
        iii. Patient has profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors OR
        iv. Patient has a diagnosis of dumping syndrome AND ONE of the following:
            a. Patient has tried and had an inadequate response to acarbose OR
            b. Patient has an intolerance or hypersensitivity to acarbose OR
            c. Patient has an FDA labeled contraindication to acarbose OR
        v. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal

Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of acromegaly OR
    B. Patient has severe diarrhea and/or flushing episodes associated with metastatic carcinoid tumors OR
    C. Patient has profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors OR
    D. Patient has a diagnosis of dumping syndrome OR
    E. Patient has another indication that is supported in CMS approved compendia for the requested agent
    AND
3. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Prior Authorization Group Description:
Somatostatin Analogs PA - Sandostatin LAR
Drug Name(s)
Sandostatin Lar Depot
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    B. ONE of the following:
        i. Patient has a diagnosis of acromegaly AND ONE of the following:
            a. Patient is not a candidate for surgical resection or pituitary radiation therapy OR
            b. The requested agent is for adjunctive therapy with pituitary radiation therapy OR
            c. Patient had an inadequate response to surgery or pituitary radiation therapy as indicated by growth hormone levels or serum IGF-1 levels that are above the reference range OR
        ii. Patient has severe diarrhea and/or flushing episodes associated with metastatic carcinoid tumors OR
        iii. Patient has profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors OR
        iv. Patient has a diagnosis of dumping syndrome AND ONE of the following:
            a. Patient has tried and had an inadequate response to acarbose OR
            b. Patient has an intolerance or hypersensitivity to acarbose OR
            c. Patient has an FDA labeled contraindication to acarbose OR
        v. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
2. Patient has responded to and tolerated octreotide for a minimum of 2 weeks prior to starting therapy with Sandostatin LAR AND
3. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:

Approval will be 6 months for initial, 12 months for renewal

Other Criteria:

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of acromegaly OR
    B. Patient has severe diarrhea and/or flushing episodes associated with metastatic carcinoid tumors OR
    C. Patient has profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors OR
    D. Patient has a diagnosis of dumping syndrome OR
    E. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Prior Authorization Group Description:
Somatostatin Analogs PA – Somavert
Drug Name(s)
Somavert
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of acromegaly AND ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. BOTH of the following:
        i. ONE of the following:
            a. Patient is not a candidate for surgical resection or pituitary radiation therapy OR
            b. The requested agent is for adjunctive therapy with pituitary radiation therapy OR
            c. Patient had an inadequate response to surgery or pituitary radiation therapy as indicated by serum IGF-1 levels that are above the reference range AND
        ii. ONE of the following:
            a. Patient has tried and had an inadequate response to octreotide or Somatuline Depot (lanreotide) OR
            b. Patient has an intolerance or hypersensitivity to octreotide or Somatuline Depot (lanreotide) OR
            c. Patient has an FDA labeled contraindication to octreotide or Somatuline Depot (lanreotide) AND
2. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of acromegaly AND
3. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal
Other Criteria:

Prior Authorization Group Description:
Sovaldi PA
Drug Name(s)
Sovaldi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The requested dose is within FDA labeled dosing or supported in AASLD/IDSA guideline dosing for the requested indication AND
5. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. Patient has an FDA labeled contraindication or hypersensitivity to TWO preferred agents: Epclusa and Harvoni for supported genotypes OR
    D. Prescriber has provided information based on FDA approved labeling or AASLD/IDSA guidelines supporting the use of the non-preferred agent for the patient's diagnosis and genotype over TWO preferred agents: Epclusa and Harvoni for supported genotypes
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported
Other Criteria:

Prior Authorization Group Description:
Spravato PA
Drug Name(s)
Spravato 56Mg Dose
Spravato 84Mg Dose
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. BOTH of the following:
    a. ONE of the following:
        i. Patient has a diagnosis of treatment-resistant depression (TRD) OR
        ii. Patient has a diagnosis of major depressive disorder (MDD) with acute suicidal ideation or behavior AND
    b. The requested agent will be used in combination with an oral antidepressant AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ALL of the following:
        i. ONE of the following:
            1. BOTH of the following:
                a. Patient has a diagnosis of treatment-resistant depression (TRD) AND
                b. Patient has tried and had an inadequate response to at least two different oral antidepressants (e.g., SSRIs, SNRIs) OR
            2. Patient has a diagnosis of major depressive disorder (MDD) with acute suicidal ideation or behavior AND
        ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., psychiatrist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND
        iii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Strensiq PA
Drug Name(s)
Strensiq
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    A. Perinatal or infantile-onset hypophosphatasia OR
    B. Juvenile-onset hypophosphatasia AND
2. Patient has documentation (i.e., medical records) of clinical manifestations to support the diagnosis of hypophosphatasia at the age of onset prior to age 18 (e.g., vitamin B6-dependent seizures, skeletal abnormalities such as rachitic chest deformity leading to respiratory problems or bowed arms/legs, “failure to thrive”) AND
3. Patient has documentation (i.e., medical records) of radiographic imaging to support the diagnosis of hypophosphatasia at the age of onset prior to age 18 (e.g., infantile rickets, alveolar bone loss, craniosynostosis, fractures) AND
4. Patient has documentation (i.e., medical records) of confirmed mutation(s) in the ALPL gene that encodes the tissue non-specific isoenzyme of alkaline phosphatase (TNSALP) AND
5. Patient has documentation (i.e., medical records) of a measured total serum alkaline phosphatase (ALP) level that is below the normal lab reference range for age and sex AND
6. Patient has documentation (i.e., medical records) of ONE of the following:
    A. Elevated urine concentration of phosphoethanolamine (PEA) OR
    B. Elevated serum concentration of pyridoxal 5'-phosphate (PLP) in the absence of vitamin supplements within one week prior to the test OR
    C. Elevated urinary inorganic pyrophosphate (PPi) AND
7. The requested dose is within FDA labeled dosing (based on the patient’s weight) for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient’s diagnosis (e.g., endocrinologist or geneticist with expertise in metabolic bone diseases) or the prescriber has consulted with a specialist in the area of the patient’s diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan’s Prior Authorization criteria AND
2. Patient has ONE of the following diagnoses:
    A. Perinatal or infantile-onset hypophosphatasia OR

B. Juvenile-onset hypophosphatasia AND

3. There is documentation (i.e., medical records) that the patient has had a decrease from baseline (before treatment with the requested agent) in at least ONE of the following levels:

a. Urine concentration of phosphoethanolamine (PEA) OR

b. Serum concentration of pyridoxal 5'-phosphate (PLP) in the absence of vitamin supplements within one week prior to the test OR

c. Urinary inorganic pyrophosphate (PPi) AND

4. Patient has documentation (i.e., medical records) of clinical improvement and/or stabilization with the requested agent (e.g., improvement in respiratory status, growth, pain, radiographic findings, other symptoms associated with the disease) AND

5. The requested dose is within FDA labeled dosing (based on the patient's weight) for the requested indication

Prior Authorization Group Description:
Substrate Reduction Therapy PA – Cerdelga
Drug Name(s)
Cerdelga
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Gaucher disease type 1 (GD1) confirmed by ONE of the following:
    A. A baseline glucocerebrosidase enzyme activity of less than or equal to 15% of mean normal in peripheral blood leukocytes, fibroblasts, or other nucleated cells OR
    B. Confirmation of genetic mutation of GBA gene with two disease-causing alleles AND
2. Patient is a CYP2D6 extensive metabolizer (EMs), intermediate metabolizer (IMs), or poor metabolizer (PMs) established by a genetic test AND
3. Prescriber has drawn baseline measurements of hemoglobin level, platelet count, liver volume, and spleen volume AND
4. Prior to any treatment for the intended diagnosis, the patient has had at least ONE of the following clinical presentations:
    A. Anemia [defined as mean hemoglobin (Hb) level below the testing laboratory's lower limit of the normal range based on age and gender] OR
    B. Thrombocytopenia (defined as platelet count of less than 100,000 per microliter) OR
    C. Hepatomegaly OR
    D. Splenomegaly OR
    E. Growth failure (i.e., growth velocity is below the standard mean for age) OR
    F. Evidence of bone disease with other causes ruled out

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Gaucher disease type 1 (GD1) AND
3. Patient has had improvements or stabilization with the requested agent as indicated by ONE of the following:
    A. Spleen volume OR
    B. Hemoglobin level OR
    C. Liver volume OR
    D. Platelet count OR
    E. Growth OR
    F. Bone pain or crisis
Age Restriction:
Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, geneticist, hematologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Substrate Reduction Therapy PA – Miglustat
Drug Name(s)
Miglustat
Yargesa
Zavesca
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Gaucher disease type 1 (GD1) confirmed by ONE of the following:
    A. A baseline glucocerebrosidase enzyme activity of less than or equal to 15% of mean normal in peripheral blood leukocytes, fibroblasts, or other nucleated cells OR
    B. Confirmation of genetic mutation of GBA gene with two disease-causing alleles AND
2. Prescriber has drawn baseline measurements of hemoglobin level, platelet count, liver volume, and spleen volume AND
3. Prior to any treatment for the intended diagnosis, the patient has had at least ONE of the following clinical presentations:
    A. Anemia [defined as mean hemoglobin (Hb) level below the testing laboratory's lower limit of the normal range based on age and gender] OR
    B. Thrombocytopenia (defined as platelet count of less than 100,000 per microliter) OR
    C. Hepatomegaly OR
    D. Splenomegaly OR
    E. Growth failure (i.e., growth velocity is below the standard mean for age) OR
    F. Evidence of bone disease with other causes ruled out

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Gaucher disease type 1 (GD1) AND
3. Patient has had improvements or stabilization with the requested agent as indicated by ONE of the following:
    A. Spleen volume OR
    B. Hemoglobin level OR
    C. Liver volume OR
    D. Platelet count OR
    E. Growth OR
    F. Bone pain or crisis
Age Restriction:
Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, geneticist, hematologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Sucraid PA
Drug Name(s)
Sucraid
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of congenital sucrase-isomaltase deficiency (CSID) AND
2. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of congenital sucrase-isomaltase deficiency (CSID) AND
3. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, endocrinologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Sunosi PA
Drug Name(s)
Sunosi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of excessive daytime sleepiness associated with narcolepsy AND BOTH of the following:
        i. ONE of the following:
            1. Patient has tried and had an inadequate response to modafinil or armodafinil OR
            2. Patient has an intolerance or hypersensitivity to modafinil or armodafinil OR
            3. Patient has an FDA labeled contraindication to modafinil or armodafinil AND
        ii. ONE of the following:
            1. Patient has tried and had an inadequate response to ONE standard stimulant agent (e.g., methylphenidate) OR
            2. Patient has an intolerance or hypersensitivity to ONE standard stimulant agent (e.g., methylphenidate) OR
            3. Patient has an FDA labeled contraindication to ONE standard stimulant agent (e.g., methylphenidate) OR
    B. Patient has a diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea (OSA) AND ONE of the following:
        i. Patient has tried and had an inadequate response to modafinil or armodafinil OR
        ii. Patient has an intolerance or hypersensitivity to modafinil or armodafinil OR
        iii. Patient has an FDA labeled contraindication to modafinil or armodafinil AND
2. Patient will NOT be using the requested agent in combination with modafinil, armodafinil, or a standard stimulant agent (e.g., methylphenidate) for the requested indication AND
3. Patient will NOT be using the requested agent in combination with OR within 14 days of a monoamine oxidase (MAO) inhibitor (e.g., phenelzine, tranylcypromine)
Age Restriction:
Patient is 18 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:

A. Patient has a diagnosis of excessive daytime sleepiness associated with narcolepsy OR
B. Patient has a diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea (OSA) AND

3. Patient will NOT be using the requested agent in combination with modafinil, armodafinil, or a standard stimulant agent (e.g., methylphenidate) for the requested indication AND
4. Patient will NOT be using the requested agent in combination with OR within 14 days of a monoamine oxidase (MAO) inhibitor (e.g., phenelzine, tranylcypromine) AND
5. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Symdeko PA
Drug Name(s)
Symdeko
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. ONE of the following:
    A. Patient has the presence of the F508del mutation on both alleles (homozygous) of the CFTR gene confirmed by genetic testing OR
    B. Patient has ONE of the CFTR gene mutations or a mutation in the CFTR gene that is responsive based on in vitro data, as indicated in the FDA label, confirmed by genetic testing OR
    C. Patient has another CFTR gene mutation(s) that is responsive to the requested agent, as indicated in the FDA label, confirmed by genetic testing AND
3. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of cystic fibrosis AND
3. Patient has had improvement or stabilization with the requested agent [e.g., improvement in FEV1 from baseline, increase in weight/BMI, improvement from baseline Cystic Fibrosis Questionnaire-Revised (CFQ-R) Respiratory Domain score, improvements in respiratory symptoms (cough, sputum production, and difficulty breathing), and/or reduced number of pulmonary exacerbations] AND
4. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cystic fibrosis, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Symproic PA
Drug Name(s)
Symproic
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has opioid-induced constipation (OIC) and chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment AND
2. Patient has chronic use of an opioid agent in the past 90 days AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to lactulose OR
    B. Patient has an intolerance or hypersensitivity to lactulose OR
    C. Patient has an FDA labeled contraindication to lactulose
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Tarpeyo PA
Drug Name(s)
Tarpeyo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy AND
2. The requested agent will be used to reduce proteinuria AND
3. Patient is at risk of rapid disease progression as shown by ONE of the following:
    A. A urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.8 g/g OR
    B. Proteinuria greater than or equal to 1 g/day AND
4. ONE of the following:
    A. Patient is currently being treated with an ACEI or ARB (e.g., benazepril, lisinopril, losartan), or a combination medication containing an ACE or ARB OR
    B. Patient has an intolerance or hypersensitivity to an ACEI or ARB, or a combination medication containing an ACE or ARB OR
    C. Patient has an FDA labeled contraindication to an ACEI or ARB, or a combination medication containing an ACE or ARB AND
5. Patient has not previously been treated with a course of therapy (10 months) with the requested agent AND
6. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., nephrologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
No prior Tarpeyo use, approve 10 months. Prior use - see Other Criteria.
Other Criteria:
Prior Tarpeyo use, approve remainder of 10 months total course of therapy.

Prior Authorization Group Description:
Tasimelteon Capsule PA
Drug Name(s)
Hetlioz
Tasimelteon
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. Patient has a diagnosis of Non-24-hour sleep-wake disorder AND
        ii. Patient is totally blind (i.e., no light perception) OR
    B. BOTH of the following:
        i. Patient has a diagnosis of Smith-Magenis Syndrome (SMS) confirmed by the presence of ONE of the following genetic mutations:
            A. A heterozygous deletion of 17p11.2 OR
            B. A heterozygous pathogenic variant involving RAI1 AND
        ii. The requested agent is being used to treat nighttime sleep disturbances associated with SMS
Age Restriction:
For diagnosis of Non-24-hour sleep-wake disorder, patient is 18 years of age or over. For diagnosis of Smith-Magenis Syndrome (SMS), patient is 16 years of age or over.
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist, sleep specialist, psychiatrist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Tavalisse PA
Drug Name(s)
Tavalisse
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of chronic immune (idiopathic) thrombocytopenia (ITP) AND
2. ONE of the following:
    A. Patient has tried and had an insufficient response to a corticosteroid, another thrombopoietin receptor agonist (e.g., Promacta), or immunoglobulin (IVIg or anti-D) OR
    B. Patient has an intolerance or hypersensitivity to a corticosteroid, another thrombopoietin receptor agonist (e.g., Promacta), or immunoglobulin (IVIg or anti-D) OR
    C. Patient has an FDA labeled contraindication to a corticosteroid, another thrombopoietin receptor agonist (e.g., Promacta), or immunoglobulin (IVIg or anti-D) OR
    D. Patient has had an insufficient response to a splenectomy

Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following:
    A. Patient's platelet count is 50 x 10^9/L or greater OR
    B. Patient's platelet count has increased sufficiently to avoid clinically significant bleeding
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal
Other Criteria:

Prior Authorization Group Description:
Tavneos PA
Drug Name(s)
Tavneos
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Severe hepatic impairment (Child-Pugh C)
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and/or microscopic polyangiitis [MPA]) AND
2. Patient will continue standard therapy (e.g., corticosteroids, azathioprine, mycophenolate mofetil) in combination with the requested agent for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., rheumatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Tegsedi PA
Drug Name(s)
Tegsedi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis AND
2. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist, neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Teriparatide PA
Drug Name(s)
Forteo
Teriparatide
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    A. Postmenopausal with osteoporosis OR
    B. Patient's sex is male with primary or hypogonadal osteoporosis OR
    C. Osteoporosis with sustained systemic glucocorticoid therapy AND
2. Patient's diagnosis was confirmed by ONE of the following:
    A. A fragility fracture in the hip or spine OR
    B. A T-score of -2.5 or lower OR
    C. A T-score of -1.0 to -2.5 AND ONE of the following:
        i. A fragility fracture of the proximal humerus, pelvis, or distal forearm OR
        ii. A FRAX 10-year probability for major osteoporotic fracture of 20% or greater OR
        iii. A FRAX 10-year probability of hip fracture of 3% or greater AND
3. ONE of the following:
    A. Patient is at a very high fracture risk as defined by ONE of the following:
        i. Patient had a recent fracture (within the past 12 months) OR
        ii. Patient had fractures while on FDA approved osteoporosis therapy OR
        iii. Patient has had multiple fractures OR
        iv. Patient had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR
        v. Patient has a very low T-score (less than -3.0) OR
        vi. Patient is at high risk for falls or has a history of injurious falls OR
        vii. Patient has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm OR
    B. ONE of the following:
        i. Patient has tried and had an inadequate response to a bisphosphonate OR
        ii. Patient has an intolerance or hypersensitivity to a bisphosphonate OR
        iii. Patient has an FDA labeled contraindication to a bisphosphonate AND
4. Patient will NOT be using the requested agent in combination with a bisphosphonate, denosumab (e.g., Prolia, Xgeva), romosozumab-aqqg, or another parathyroid hormone analog (e.g., abaloparatide) for the requested indication AND

Criteria continues: see Other Criteria
Age Restriction:

Prescriber Restrictions:

Coverage Duration:

No prior teriparatide and/or Tymlos use approve 2 years, Prior use - see Other Criteria

Other Criteria:

5. The requested dose is within FDA labeled dosing for the requested indication AND
6. ONE of the following:
    A. Patient has never received treatment with teriparatide or Tymlos (abaloparatide) OR
    B. Patient has been previously treated with teriparatide or Tymlos (abaloparatide) AND ONE of the following:
        i. The total cumulative duration of treatment with teriparatide and Tymlos (abaloparatide) has NOT exceeded 2 years OR
        ii. Patient has received 2 years or more of treatment with teriparatide, and remains at or has returned to having a high risk for fracture

Prior teriparatide and/or Tymlos use approve remainder of 2 years of total cumulative therapy. Approve 1 year if patient has received 2 years or more teriparatide

Prior Authorization Group Description:
Tetrabenazine PA
Drug Name(s)
Tetrabenazine
Xenazine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of chorea associated with Huntington's disease OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. Patient does NOT have a current diagnosis of depression OR
    B. Patient has a current diagnosis of depression and is being treated for depression AND
3. ONE of the following:
    A. Patient does NOT have a diagnosis of suicidal ideation and/or behavior OR
    B. Patient has a diagnosis of suicidal ideation and/or behavior and must NOT be actively suicidal AND
4. Patient will NOT be using the requested agent in combination with a monoamine oxidase inhibitor (MAOI) AND
5. Patient will NOT be using the requested agent in combination with reserpine
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Tezspire PA
Drug Name(s)
Tezspire
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of severe asthma AND
2. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LRTA, LAMA, theophylline) in combination with the requested agent AND
3. Patient will NOT be using the requested agent in combination with Xolair, an IL-5 inhibitor (Cinqair, Fasenra, Nucala), or Dupixent for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of severe asthma AND
3. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LRTA, LAMA, theophylline) in combination with the requested agent AND
4. Patient has had clinical benefit with the requested agent AND
5. Patient will NOT be using the requested agent in combination with Xolair, an IL-5 inhibitor (Cinqair, Fasenra, Nucala), or Dupixent for the requested indication
Age Restriction:
Patient is 12 years of age or over
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Tlando PA
Drug Name(s)
Tlando
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient's sex is male with a diagnosis of primary or secondary (hypogonadotropic) hypogonadism AND
2. ONE of the following:
    A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels:
        i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR
        ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR
    B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels:
        i. Total serum testosterone level that is within OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR
        ii. Free serum testosterone level is within OR below the testing laboratory's normal range AND
3. ONE of the following:
    A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR
    B. Prescriber has provided information in support of therapy with more than one agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Tobi Podhaler PA
Drug Name(s)
Tobi Podhaler
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. Documentation has been provided that indicates the patient has a Pseudomonas aeruginosa respiratory infection AND
3. ONE of the following:
    a. Patient is NOT currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam, inhaled tobramycin) OR
    b. Patient is currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam, inhaled tobramycin) AND ONE of the following:
        i. Prescriber has confirmed that the other inhaled antibiotic will be discontinued, and that therapy will be continued only with the requested agent OR
        ii. Prescriber has provided information in support of another inhaled antibiotic therapy used concurrently with or alternating with (i.e., continuous alternating therapy) the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Tobramycin neb PA
Drug Name(s)
Kitabis Pak
Tobi
Tobramycin Neb
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. Documentation has been provided that indicates the patient has a Pseudomonas aeruginosa respiratory infection AND
3. ONE of the following:
    a. Patient is NOT currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam, inhaled tobramycin) OR
    b. Patient is currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam, inhaled tobramycin) AND ONE of the following:
        i. Prescriber has confirmed that the other inhaled antibiotic will be discontinued, and that therapy will be continued only with the requested agent OR
        ii. Prescriber has provided information in support of another inhaled antibiotic therapy used concurrently with or alternating with (i.e., continuous alternating therapy) the requested agent

Drug is also subject to Part B versus Part D review.
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Topical Diclofenac 3% Gel PA
Drug Name(s)
Diclofenac Sodium 3% Gel
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has a diagnosis of actinic keratosis (AK)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 3 months
Other Criteria:

Prior Authorization Group Description:
Topical Doxepin PA
Drug Name(s)
Doxepin Hydrochloride
Prudoxin
Zonalon
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    a. Patient has a diagnosis of moderate pruritus associated with atopic dermatitis AND ONE of the following:
        i. Patient has tried and had an inadequate response to a topical corticosteroid (e.g., hydrocortisone, triamcinolone) OR
        ii. Patient has an intolerance or hypersensitivity to a topical corticosteroid OR
        iii. Patient has an FDA labeled contraindication to a topical corticosteroid OR
    b. Patient has a diagnosis of moderate pruritus associated with lichen simplex chronicus AND ONE of the following:
        i. Patient has tried and had an inadequate response to a topical corticosteroid (e.g., hydrocortisone, triamcinolone) OR
        ii. Patient has an intolerance or hypersensitivity to a topical corticosteroid OR
        iii. Patient has an FDA labeled contraindication to a topical corticosteroid
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 8 days
Other Criteria:

Prior Authorization Group Description:
Topical NSAID PA – Flector
Drug Name(s)
Diclofenac Epolamine
Flector
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
3 months for acute pain, 12 months for all other diagnoses
Other Criteria:

Prior Authorization Group Description:
Topical NSAID PA – Licart
Drug Name(s)
Licart
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
3 months for acute pain, 12 months for all other diagnoses
Other Criteria:

Prior Authorization Group Description:
Topical NSAID PA – Pennsaid
Drug Name(s)
Diclofenac Sodium (Pennsaid)
Pennsaid
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
3 months for acute pain, 12 months for all other diagnoses
Other Criteria:

Prior Authorization Group Description:
Topical Retinoids PA – Adapalene
Drug Name(s)
Adapalene
Adapalene Pump
Differin
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for cosmetic purposes
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Topical Retinoids PA – Tazarotene
Drug Name(s)
Arazlo
Fabior
Tazarotene
Tazorac
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for cosmetic purposes
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Topical Retinoids PA – Tretinoin
Drug Name(s)
Altreno
Atralin
Avita
Retin-A
Retin-A Micro
Retin-A Micro Pump
Tretinoin Cream, Gel
Tretinoin Microsphere
Tretinoin Microsphere Pump
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for cosmetic purposes
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Topical Retinoids PA – Trifarotene
Drug Name(s)
Aklief
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for cosmetic purposes
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Trelstar PA
Drug Name(s)
Trelstar Mixject
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. BOTH of the following:
        i. Patient is NOT currently being treated with the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
3. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Trientine PA
Drug Name(s)
Syprine
Trientine Hydrochloride
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of Wilson's disease confirmed by ONE of the following:
    A. Confirmation of genetic mutation of the ATP7B gene OR
    B. Patient has TWO or more of the following:
        i. Presence of hepatic abnormality (e.g., acute liver failure, cirrhosis, fatty liver)
        ii. Presence of Kayser-Fleischer rings
        iii. Serum ceruloplasmin level less than 20 mg/dL
        iv. Basal urinary copper excretion greater than 40 mcg/24 hours or the testing laboratory's upper limit of normal
        v. Hepatic parenchymal copper content greater than 40 mcg/g dry weight
        vi. Presence of neurological symptoms (e.g., dystonia, hypertonia, rigidity with tremors, dysarthria, muscle spasms, dysphasia, polyneuropathy, dysautonomia) AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to penicillamine OR
    B. Patient has an intolerance or hypersensitivity to penicillamine OR
    C. Patient has an FDA labeled contraindication to penicillamine

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Wilson's disease AND
3. Patient has had clinical benefit with the requested agent as evidenced by ONE of the following:
    A. Improvement and/or stabilization in hepatic abnormality OR
    B. Reduction in Kayser-Fleischer rings OR
    C. Improvement and/or stabilization in neurological symptoms (e.g., dystonia, hypertonia, rigidity with tremors, dysarthria, muscle spasms, dysphasia, polyneuropathy, dysautonomia) OR
    D. Basal urinary copper excretion greater than 200 mcg/24 hours
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist, neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Trikafta PA
Drug Name(s)
Trikafta
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. ONE of the following:
    A. Patient has the presence of the F508del mutation in at least ONE allele (heterozygous OR homozygous) of the CFTR gene confirmed by genetic testing OR
    B. Patient has ONE of the CFTR gene mutations or a mutation in the CFTR gene that is responsive based on in vitro data, as indicated in the FDA label, confirmed by genetic testing OR
    C. Patient has another CFTR gene mutation(s) that is responsive to the requested agent, as indicated in the FDA label, confirmed by genetic testing AND
3. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of cystic fibrosis AND
3. Patient has had improvement or stabilization with the requested agent [e.g., improvement in FEV1 from baseline, increase in weight/BMI, improvement from baseline Cystic Fibrosis Questionnaire-Revised (CFQ-R) Respiratory Domain score, improvements in respiratory symptoms (cough, sputum production, and difficulty breathing), and/or reduced number of pulmonary exacerbations] AND
4. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cystic fibrosis, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Trudhesa PA
Drug Name(s)
Trudhesa
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. The requested agent will be used for the treatment of acute migraine with or without aura AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to TWO triptan agents with differing active ingredients (e.g., sumatriptan, rizatriptan) OR
    B. Patient has an intolerance or hypersensitivity to TWO triptan agents with differing active ingredients OR
    C. Patient has an FDA labeled contraindication to TWO triptan agents with differing active ingredients AND
3. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, acute CGRP)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. The requested agent will be used for the treatment of acute migraine with or without aura AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, acute CGRP)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Trulicity PA
Drug Name(s)
Trulicity
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of type 2 diabetes mellitus AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. BOTH of the following:
        i. ONE of the following:
            1. Patient's medication history includes use of an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) within the past 90 days OR
            2. Patient had an ineffective treatment response to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            3. Patient has an intolerance or hypersensitivity to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            4. Patient has an FDA labeled contraindication to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            5. BOTH of the following:
                a. Patient has a diagnosis of established cardiovascular disease [e.g., myocardial infarction, stroke, any revascularization procedure, transient ischemic attack, unstable angina, amputation, symptomatic or asymptomatic coronary artery disease] AND
                b. The requested agent will be used to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Tymlos PA
Drug Name(s)
Tymlos
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient (pt) has ONE of the following:
    A. Postmenopausal with osteoporosis OR
    B. Pt's sex is male with osteoporosis AND
2. BOTH of the following:
    A. Pt's diagnosis was confirmed by ONE of the following:
        i. A fragility fracture in the hip or spine OR
        ii. A T-score of -2.5 or lower OR
        iii. A T-score of -1.0 to -2.5 AND ONE of the following:
            a. A fragility fracture of proximal humerus, pelvis, or distal forearm OR
            b. A FRAX 10-year probability for major osteoporotic fracture of 20% or greater OR
            c. A FRAX 10-year probability of hip fracture of 3% or greater AND
    B. ONE of the following:
        i. Pt is at a very high fracture risk as defined by ONE of the following:
            a. Pt had a recent fracture (within the past 12 months) OR
            b. Pt had fractures while on FDA approved osteoporosis therapy OR
            c. Pt has had multiple fractures OR
            d. Pt had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR
            e. Pt has a very low T-score (less than -3.0) OR
            f. Pt is at high risk for falls or has a history of injurious falls OR
            g. Pt has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm OR
        ii. ONE of the following:
            a. Pt has tried and had an inadequate response to a bisphosphonate OR
            b. Pt has an intolerance or hypersensitivity to a bisphosphonate OR
            c. Pt has an FDA labeled contraindication to a bisphosphonate AND
3. Pt will NOT be using the requested agent in combination with a bisphosphonate, denosumab (e.g., Prolia, Xgeva), romosozumab-aqqg, or another parathyroid hormone analog (e.g., teriparatide) for the requested indication AND
4. The requested dose is within FDA labeled dosing for the requested indication AND
5. The total cumulative duration of treatment with teriparatide and Tymlos (abaloparatide) has not exceeded 2 years

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
No prior Tymlos and/or teriparatide use approve 2 years, Prior use - see Other Criteria
Other Criteria:
Prior Tymlos and/or teriparatide use approve remainder of 2 years of total cumulative therapy

Prior Authorization Group Description:
Tyrvaya PA
Drug Name(s)
Tyrvaya
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Ubrelvy PA
Drug Name(s)
Ubrelvy
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of migraine AND
2. The requested agent is being used for the treatment of acute migraine with or without aura AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to a triptan (e.g., sumatriptan, rizatriptan) agent OR
    B. Patient has an intolerance, or hypersensitivity to a triptan OR
    C. Patient has an FDA labeled contraindication to a triptan AND
4. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of migraine AND
3. The requested agent is being used for the treatment of acute migraine with or without aura AND
4. Patient has had clinical benefit with the requested agent AND
5. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Urea Cycle Disorders PA – Olpruva
Drug Name(s)
Olpruva
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of urea cycle disorders (UCDs), involving deficiencies of carbamylphosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS) AND
2. The requested agent will be used as chronic management of UCDs AND
3. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist (e.g., geneticist, metabolic disorders) or the prescriber has consulted with a specialist
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Urea Cycle Disorders PA – Pheburane
Drug Name(s)
Pheburane
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of urea cycle disorders (UCDs), involving deficiencies of carbamylphosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS) AND
2. The requested agent will be used as chronic management of UCDs AND
3. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist (e.g., geneticist, metabolic disorders) or the prescriber has consulted with a specialist
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Urea Cycle Disorders PA – Ravicti
Drug Name(s)
Ravicti
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of urea cycle disorder and the requested agent will be used for chronic management AND
2. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist, metabolic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Urea Cycle Disorders PA - Sodium Phenylbutyrate
Drug Name(s)
Buphenyl
Sodium Phenylbutyrate
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of ONE of the following:
a. Urea cycle disorder with neonatal-onset involving deficiencies of carbamylphosphate synthetase, ornithine transcarbamylase, or argininosuccinic acid synthetase OR
b. Urea cycle disorder with late-onset and history of hyperammonemic encephalopathy involving deficiencies of carbamylphosphate synthetase, ornithine transcarbamylase, or argininosuccinic acid synthetase AND
2. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist, metabolic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Veozah PA
Drug Name(s)
Veozah
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Viberzi PA
Drug Name(s)
Viberzi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has a diagnosis of irritable bowel syndrome with diarrhea (IBS-D)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Victoza PA
Drug Name(s)
Victoza
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of type 2 diabetes mellitus AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. BOTH of the following:
        i. ONE of the following:
            1. Patient's medication history includes use of an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) within the past 90 days OR
            2. Patient had an ineffective treatment response to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            3. Patient has an intolerance or hypersensitivity to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            4. Patient has an FDA labeled contraindication to an oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR
            5. BOTH of the following:
                a. Patient has a diagnosis of established cardiovascular disease [e.g., myocardial infarction, stroke, any revascularization procedure, transient ischemic attack, unstable angina, amputation, symptomatic or asymptomatic coronary artery disease] AND
                b. The requested agent will be used to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Vijoice PA
Drug Name(s)
Vijoice
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS) confirmed by genetic testing indicating a mutation in the PIK3CA gene AND
2. Patient has severe manifestations of PROS AND
3. Patient requires systemic therapy

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS) AND
3. Patient has severe manifestations of PROS AND
4. Patient requires systemic therapy AND
5. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:

Vivjoa PA

Drug Name(s)

Vivjoa

Indications:

All FDA-Approved Indications.

Off-Label Uses:

Exclusion Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require ALL of the following:

1. Patient has a diagnosis of vulvovaginal candidiasis AND
2. The requested agent will be used to reduce the incidence of recurrent vulvovaginal candidiasis AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to fluconazole OR
    B. Patient has an intolerance or hypersensitivity to fluconazole OR
    C. Patient has an FDA labeled contraindication to fluconazole OR
    D. Patient will be using fluconazole as part of the fluconazole/Vivjoa dosage regimen

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 4 months

Other Criteria:

Prior Authorization Group Description:
Voriconazole PA
Drug Name(s)
Vfend
Vfend Iv
Voriconazole
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of invasive Aspergillus OR
    B. Patient has a serious infection caused by Scedosporium apiospermum or Fusarium species OR
    C. Patient has a diagnosis of esophageal candidiasis or candidemia in nonneutropenic patient AND ONE of the following:
        i. Patient has tried and had an inadequate response to fluconazole or an alternative antifungal agent OR
        ii. Patient has an intolerance or hypersensitivity to fluconazole or an alternative antifungal agent OR
        iii. Patient has an FDA labeled contraindication to fluconazole or an alternative antifungal agent OR
    D. Patient has a diagnosis of blastomycosis AND ONE of the following:
        i. Patient has tried and had an inadequate response to itraconazole OR
        ii. Patient has an intolerance or hypersensitivity to itraconazole OR
        iii. Patient has an FDA labeled contraindication to itraconazole OR
    E. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida AND patient is severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR
    F. Patient has another indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
One month for esophageal candidiasis, 6 months for all other indications
Other Criteria:
Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND

2. ONE of the following:

A. Patient has a diagnosis of invasive Aspergillus, a serious infection caused by Scedosporium apiospermum or Fusarium species, esophageal candidiasis, candidemia in nonneutropenic patient, or blastomycosis and patient has continued indicators of active disease (e.g., continued radiologic findings, positive cultures, positive serum galactomannan assay for Aspergillus) OR

B. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida and patient continues to be severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR

C. BOTH of the following:

i. Patient has another indication that is supported in CMS approved compendia for the requested agent AND

ii. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Vosevi PA
Drug Name(s)
Vosevi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The requested dose is within FDA labeled dosing or supported in AASLD/IDSA guideline dosing for the requested indication AND
5. If genotype 1, the patient's subtype has been identified and provided
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported
Other Criteria:

Prior Authorization Group Description:
Vowst PA
Drug Name(s)
Vowst
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. The requested agent will be used to prevent the recurrence of Clostridioides difficile infection (CDI) AND
2. Patient has had a confirmed diagnosis of recurrent CDI as defined by greater than or equal to 3 episodes of CDI in a 12 month period AND
3. Patient has completed a standard of care antibiotic regimen (e.g., vancomycin, fidaxomicin) for recurrent CDI at least 2 to 4 days before initiating treatment with the requested agent AND
4. Patient will NOT be using the requested agent in combination with any antibiotic regimen for any indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., infectious disease, gastroenterologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Voxzogo PA
Drug Name(s)
Voxzogo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of achondroplasia AND
2. The requested agent will be used to increase linear growth AND
3. Patient has open epiphyses

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of achondroplasia AND
3. The requested agent will be used to increase linear growth AND
4. Patient has open epiphyses AND
5. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Vtama PA
Drug Name(s)
Vtama
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of plaque psoriasis AND
2. ONE of the following:
    a. Patient has tried and failed a topical corticosteroid (e.g., triamcinolone) OR
    b. Patient has an intolerance or hypersensitivity to a topical steroid OR
    c. Patient has an FDA labeled contraindication to a topical steroid AND
3. ONE of the following:
    a. Patient has tried and failed a topical vitamin D analog (e.g., calcipotriene) OR tazarotene OR
    b. Patient has an intolerance or hypersensitivity to a topical vitamin D analog OR tazarotene OR
    c. Patient has an FDA labeled contraindication to a topical vitamin D analog OR tazarotene

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of plaque psoriasis AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Vyepti PA
Drug Name(s)
Vyepti
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of migraine AND
2. The requested agent is being used for migraine prophylaxis AND
3. Patient has 4 migraine headaches or more per month AND
4. ONE of the following:
    A. Patient has tried and had an inadequate response to a conventional migraine prophylaxis agent [e.g., beta blockers (propranolol), anticonvulsants (divalproex, topiramate)] OR
    B. Patient has an intolerance, or hypersensitivity to a conventional migraine prophylaxis agent OR
    C. Patient has an FDA labeled contraindication to a conventional migraine prophylaxis agent AND
5. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of migraine AND
3. The requested agent is being used for migraine prophylaxis AND
4. Patient has had clinical benefit with the requested agent AND
5. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Vyndamax PA
Drug Name(s)
Vyndamax
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) AND
2. The requested agent will be used to reduce cardiovascular mortality and cardiovascular-related hospitalization AND
3. Patient will NOT be using the requested agent in combination with another tafamidis agent for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) AND
3. The requested agent will be used to reduce cardiovascular mortality and cardiovascular-related hospitalization AND
4. Patient has had clinical benefit with the requested agent AND
5. Patient will NOT be using the requested agent in combination with another tafamidis agent for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Vyndaqel PA
Drug Name(s)
Vyndaqel
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) AND
2. The requested agent will be used to reduce cardiovascular mortality and cardiovascular-related hospitalization AND
3. Patient will NOT be using the requested agent in combination with another tafamidis agent for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) AND
3. The requested agent will be used to reduce cardiovascular mortality and cardiovascular-related hospitalization AND
4. Patient has had clinical benefit with the requested agent AND
5. Patient will NOT be using the requested agent in combination with another tafamidis agent for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Wakix PA
Drug Name(s)
Wakix
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of narcolepsy with cataplexy OR
    B. Patient has a diagnosis of excessive daytime sleepiness associated with narcolepsy AND BOTH of the following:
        i. ONE of the following:
            1. Patient has tried and had an inadequate response to modafinil or armodafinil OR
            2. Patient has an intolerance or hypersensitivity to modafinil or armodafinil OR
            3. Patient has an FDA labeled contraindication to modafinil or armodafinil AND
        ii. ONE of the following:
            1. Patient has tried and had an inadequate response to ONE standard stimulant agent (e.g., methylphenidate) OR
            2. Patient has an intolerance or hypersensitivity to ONE standard stimulant agent (e.g., methylphenidate) OR
            3. Patient has an FDA labeled contraindication to ONE standard stimulant agent (e.g., methylphenidate)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of narcolepsy with cataplexy OR
    B. Patient has a diagnosis of excessive daytime sleepiness associated with narcolepsy AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is 18 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Winlevi PA
Drug Name(s)
Winlevi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for cosmetic purposes
Required Medical Information:
Criteria for approval require the following:
1. Patient has a diagnosis of acne vulgaris
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Xdemvy PA
Drug Name(s)
Xdemvy
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for cosmetic purposes
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 6 weeks
Other Criteria:

Prior Authorization Group Description:
Xembify PA
Drug Name(s)
Xembify
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ONE of the following:
1. Patient has ONE of the following diagnoses:
    A. Primary immunodeficiency [e.g., congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency] OR
    B. Multiple sclerosis (MS) AND BOTH of the following:
        i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND
        ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication to TWO MS agents (e.g., Avonex, Betaseron, Copaxone, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Mayzent, Plegridy, teriflunomide, Vumerity) OR
2. ONE of the following:
    A. Patient has another FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Drug is also subject to Part B versus Part D review.
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Xermelo PA
Drug Name(s)
Xermelo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of carcinoid syndrome diarrhea AND
2. Patient has tried and had an inadequate response to treatment with a somatostatin analog (e.g., Sandostatin [octreotide], Sandostatin LAR [octreotide], Somatuline Depot [lanreotide]) AND
3. The requested agent will be used in combination with a somatostatin analog (e.g., Sandostatin [octreotide], Sandostatin LAR [octreotide], Somatuline Depot [lanreotide])

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of carcinoid syndrome diarrhea AND
3. Patient has had clinical benefit with the requested agent (e.g., reduction in the average number of daily bowel movements) AND
4. The requested agent will be used in combination with a somatostatin analog (e.g., Sandostatin [octreotide], Sandostatin LAR [octreotide], Somatuline Depot [lanreotide])
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Xgeva PA
Drug Name(s)
Xgeva
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of multiple myeloma AND BOTH of the following:
        i. The requested agent will be used for the prevention of skeletal-related events AND
        ii. ONE of the following:
            1. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR
            2. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR
            3. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR
    B. Patient has a diagnosis of prostate cancer AND ALL of the following:
        i. The requested agent will be used for the prevention of skeletal-related events AND
        ii. Patient has bone metastases AND
        iii. ONE of the following:
            1. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR
            2. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR
            3. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR

Criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
    C. Patient has a solid tumor cancer diagnosis (e.g., thyroid, non-small cell lung, kidney cancer, or breast cancer) AND ALL of the following:
        i. The requested agent will be used for the prevention of skeletal-related events AND
        ii. Patient has bone metastases AND

iii. ONE of the following:

1. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR
2. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR
3. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR

D. Patient has a diagnosis of giant cell tumor of bone AND ONE of the following:

i. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR

ii. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR

iii. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR

E. Patient has a diagnosis of hypercalcemia of malignancy AND

2. Patient will NOT be using the requested agent in combination with Prolia (denosumab) AND
3. The requested dose is within FDA labeled dosing for the requested indication

Prior Authorization Group Description:
Xifaxan PA
Drug Name(s)
Xifaxan
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has ONE of the following:
    a. A diagnosis of irritable bowel syndrome with diarrhea (IBS-D) OR
    b. A diagnosis of hepatic encephalopathy [reduction in risk of overt hepatic encephalopathy (HE) recurrence] OR
    c. BOTH of the following:
        i. A diagnosis of traveler's diarrhea (TD) AND
        ii. The traveler's diarrhea is caused by noninvasive strains of Escherichia coli
Age Restriction:
For diagnosis of traveler's diarrhea (TD), patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Xolair PA
Drug Name(s)
Xolair
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. ONE of the following:
A. Patient has a diagnosis of moderate to severe persistent asthma AND ALL of the following:
i. ONE of the following:
a. Patient is 6 to less than 12 years of age AND BOTH of the following:
I. Patient's pretreatment IgE level is 30 IU/mL to 1300 IU/mL AND
II. Patient's weight is 20 kg to 150 kg OR
b. Patient is 12 years of age or over AND BOTH of the following:
I. Patient's pretreatment IgE level is 30 IU/mL to 700 IU/mL AND
II. Patient's weight is 30 kg to 150 kg AND
iii. Allergic asthma has been confirmed by a positive skin test or in vitro reactivity test (RAST) to a perennial aeroallergen AND
iv. ONE of the following:
a. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LRTA, LAMA, theophylline) in combination with the requested agent OR
b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an asthma control therapy OR
B. Patient has a diagnosis of chronic idiopathic urticaria AND BOTH of the following:
i. Patient has had over 6 weeks of hives and itching AND
ii. ONE of the following:
a. Patient has tried and had an inadequate response to maximum tolerable H1 antihistamine therapy OR
b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to H1 antihistamine therapy OR
C. Patient has a diagnosis of nasal polyps AND BOTH of the following:
i. ONE of the following:
a. Patient has tried and had an inadequate response to an intranasal corticosteroid OR
b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an intranasal corticosteroid AND
ii. ONE of the following:
a. The requested agent will be used in combination with an intranasal corticosteroid OR

b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an intranasal corticosteroid AND

Initial criteria continues: see Other Criteria

Age Restriction:

For diagnosis of moderate to severe persistent asthma, patient is 6 years of age or over. For diagnosis of chronic idiopathic urticaria, patient is 12 years of age or over. For diagnosis of nasal polyps, patient is 18 years of age or over.

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, otolaryngologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be 6 months for initial, 12 months for renewal

Other Criteria:

2. Patient will NOT be using the requested agent in combination with Dupixent or an injectable Interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Fasenra, Nucala) for the requested indication AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of moderate to severe persistent asthma AND ALL of the following:
        i. Patient's weight is within the FDA indicated range for their age (i.e., 20 kg to 150 kg for patients age 6 to less than 12 years and 30 kg to 150 kg for patients 12 years of age or over) AND
        ii. Patient has had clinical benefit with the requested agent AND
        iii. ONE of the following:
            a. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LRTA, LAMA, theophylline) in combination with the requested agent OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an asthma control therapy OR
    B. Patient has a diagnosis of chronic idiopathic urticaria AND the following:
        a. Patient has had clinical benefit with the requested agent OR
    C. Patient has a diagnosis of nasal polyps AND the following:
        a. Patient has had clinical benefit with the requested agent AND
3. Patient will NOT be using the requested agent in combination with Dupixent or an injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Fasenra, Nucala) for the requested indication AND
4. The requested dose is within FDA labeled dosing for the requested indication

Prior Authorization Group Description:
Xywav PA
Drug Name(s)
Xywav
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of narcolepsy with cataplexy OR
    B. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness AND BOTH of the following:
        i. ONE of the following:
            a. Patient is under 18 years of age OR
            b. ONE of the following:
                1. Patient has tried and had an inadequate response to modafinil or armodafinil OR
                2. Patient has an intolerance or hypersensitivity to modafinil or armodafinil OR
                3. Patient has an FDA labeled contraindication to modafinil or armodafinil AND
        ii. ONE of the following:
            a. Patient has tried and had an inadequate response to ONE standard stimulant agent (e.g., methylphenidate) OR
            b. Patient has an intolerance or hypersensitivity to ONE standard stimulant agent (e.g., methylphenidate) OR
            c. Patient has an FDA labeled contraindication to ONE standard stimulant agent (e.g., methylphenidate) OR
    C. Patient has a diagnosis of idiopathic hypersomnia OR
    D. Patient has another indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
For diagnosis of narcolepsy with cataplexy, patient is 7 years of age or over. For diagnosis of narcolepsy with excessive daytime sleepiness, patient is 7 years of age or over. For diagnosis of idiopathic hypersomnia, patient is 18 years of age or over.
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Zavzpret PA
Drug Name(s)
Zavzpret
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of migraine AND
2. The requested agent is being used for the treatment of acute migraine with or without aura AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to a triptan (e.g., sumatriptan, rizatriptan) agent OR
    B. Patient has an intolerance, or hypersensitivity to a triptan OR
    C. Patient has an FDA labeled contraindication to a triptan AND
4. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of migraine AND
3. The requested agent is being used for the treatment of acute migraine with or without aura AND
4. Patient has had clinical benefit with the requested agent AND
5. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Zepatier PA
Drug Name(s)
Zepatier
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The requested dose is within FDA labeled dosing or supported in AASLD/IDSA guideline dosing for the requested indication AND
5. If genotype 1, the patient's subtype has been identified and provided AND
6. If genotype 1a, the prescriber has tested the patient for the presence of virus with NS5A resistance-associated polymorphisms AND
7. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
    C. Patient has an FDA labeled contraindication or hypersensitivity to TWO preferred agents: Epclusa and Harvoni for supported genotypes OR
    D. Prescriber has provided information based on FDA approved labeling or AASLD/IDSA guidelines supporting the use of the non-preferred agent for the patient's diagnosis and genotype over TWO preferred agents: Epclusa and Harvoni for supported genotypes

Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported
Other Criteria:

Prior Authorization Group Description:
Zokinvy PA
Drug Name(s)
Zokinvy
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. Patient has a diagnosis of Hutchinson-Gilford progeria syndrome (HGPS) AND
        ii. Genetic testing has confirmed a pathogenic variant in the LMNA gene that results in production of progerin OR
    B. Patient has a diagnosis of processing-deficient progeroid laminopathy AND ONE of the following:
        i. Genetic testing has confirmed heterozygous LMNA mutation with progerin-like protein accumulation OR
        ii. Genetic testing has confirmed homozygous or compound heterozygous ZMPSTE24 mutations

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of ONE of the following:
    A. Hutchinson-Gilford progeria syndrome (HGPS) OR
    B. Processing-deficient progeroid laminopathies with either: heterozygous LMNA mutation with progerin-like protein accumulation OR homozygous or compound heterozygous ZMPSTE24 mutations AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist, geneticist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Zoryve PA
Drug Name(s)
Zoryve
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of plaque psoriasis AND
2. ONE of the following:
    a. Patient has tried and failed a topical corticosteroid (e.g., triamcinolone) OR
    b. Patient has an intolerance or hypersensitivity to a topical steroid OR
    c. Patient has an FDA labeled contraindication to a topical steroid AND
3. ONE of the following:
    a. Patient has tried and failed a topical vitamin D analog (e.g., calcipotriene) OR tazarotene OR
    b. Patient has an intolerance or hypersensitivity to a topical vitamin D analog OR tazarotene OR
    c. Patient has an FDA labeled contraindication to a topical vitamin D analog OR tazarotene

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of plaque psoriasis AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Zyclara PA
Drug Name(s)
Imiquimod (Zyclara)
Imiquimod Pump
Zyclara
Zyclara Pump
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ONE of the following:
1. Patient has a diagnosis of actinic keratosis OR
2. Patient has a diagnosis of external genital and/or perianal warts/condyloma acuminata AND the requested agent is Zyclara/imiquimod 3.75%
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
External genital and/or perianal warts/condyloma acuminata: 8 weeks
Actinic keratosis: 6 weeks
Other Criteria: