2026 PRIOR AUTHORIZATION CRITERIA

TABLE OF CONTENTS

Abilify 49
Abilify Mycite Maintenance Kit 49
Abilify Mycite Starter Kit 49
Abiraterone Acetate 496
Abirtega 496
Abrilada 80
Absorica 310
Absorica Ld 20
Accutane 310
Actemra 82
Actemra Actpen 82
Acthar 21
Actimmune 23
Acyclovir 24
Adalimumab-Aacf 104
Adalimumab-Aacf Starter Pack/Cd/Uc/Hs (6 Pen) 104
Adalimumab-Aacf Starter Pack/Psoriasis/Uveitis (4 Pen) 104
Adalimumab-Aaty Cd/Uc/Hs Starter 146
Adalimumab-Aaty Kit 146
Adalimumab-Adaz 102
Adalimumab-Fkjp 98
Adapalene 543
Adapalene Pump 543
Adbry 25
Adcirca 457
Adempas 443
Afinitor 496
Afinitor Disperz 496
Agamree 26
Aimovig 27
Ajovy 28
Akeega 496
Aklief 546
Alcohol Swabs 29
Alecensa 496
Alosetron Hcl 30
Altreno 545
Alunbrig 496
Alvaiz 34
Alyftrek 36
Alyq 457

Ambrisentan....445
Amjevita....84
Amnesteem....310
Ampyra....199
Ancobon....242
Apokyn....51
Apomorphine Hcl....51
Aptensio Xr....52
Aqneursa....53
Aralast Np....31
Aranesp Albumin Free....222
Arazlo....544
Arcalyst....54
Arikayce....55
Aripiprazole....49
Aripiprazole Odt....49
Armodafinil....56
Ascomp/Codeine....292
Asenapine Maleate Sl....49
Ativan....74
Atovaquone....60
Atralin....545
Attruby....61
Aubagio....366
Augtyro....496
Austedo....62
Austedo Xr....62
Austedo Xr Patient Titration Kit....62
Aveed....39
Avmapki Fakzynja Co-Pack....496
Avonex....353
Avonex Pen....353
Ayvakit....496
Azmiro....40
Azstarys....63
Bafiertam....354
Balversa....496
Belbuca....395
Belsomra....64
Benlysta SC....66
Berinert....276
Besremi....496
Betaseron....355
Bethkis....77
Bexarotene Capsules....496
Bexarotene Gel....78
Bimzelx....86
Bivigam....151

Bomyntra 153
Bonjesta 292
Bonsity 532
Bosentan 447
Bosulif 496
Braftovi 496
Brukinsa 496
Budesonide Dr (Entocort) 154
Budesonide Er (Uceris) 155
Buphenyl 562
Buprenorphine 395
Butalbital/Acetaminophen/Caffeine/Codeine 292
Butalbital/Aspirin/Caffeine/Codeine 292
Butrans 395
Bylvay 157
Bylvay (Pellets) 157
Cabometyx 496
Calquence 496
Camzyos 158
Caprelsa 496
Carbaglu 159
Carbinoxamine Maleate 292
Carglumic Acid 159
Cayston 160
Cequa 391
Cerdelga 521
Cerezyme 249
Chenodal 161
Chlordiazepoxide Hcl 67
Chlordiazepoxide/Amitriptyline 68
Chlorpromazine Hcl 49
Chorionic Gonadotropin 162
Cialis 65
Cibinqo 163
Cimzia 88
Cimzia Starter Kit 88
Cinacalcet Hcl 164
Cinqair 165
Cinryze 278
Claravis 310
Clemastine Fumarate 292
Clobazam 69
Clorazepate Dipotassium 70
Clozapine 49
Clozapine Odt 49
Clozaril 49
Cobenfy 166
Cobenfy Starter Pack 166

Cometriq 496
Concerta 182
Conexxence 168
Conzip 411
Copaxone 358
Copiktra 496
Corlanor 183
Cortrophin 184
Cosentyx 90
Cosentyx Sensoready Pen 90
Cosentyx Unoready 90
Cotellic 496
Cotempla Xr-Odt 186
Crenessity 187
Cresemba 188
Crinone 189
Crotan 190
Crysvita 191
Cutaquig 193
Cuvrior 194
Cyltezo 92
Cyltezo Starter Package For Crohns Disease/Uc/Hs 92
Cyltezo Starter Package For Psoriasis 92
Cyltezo Starter Package For Psoriasis/Uveitis 92
Cyproheptadine Hcl 292
Cystadrops 195
Cystagon 197
Cystaran 196
Dalfampridine Er 199
Daliresp 492
Danazol 38
Danziten 496
Daraprim 466
Dasatinib 496
Daurismo 496
Daybue 200
Daytrana 346
Dayvigo 201
Deferasirox (Exjade) 308
Deferasirox (Jadenu) 309
Deferiprone 202
Deflazacort 203
Depo-Testosterone 42
Dexmethylphenidate Hcl (Focalin) 243
Dexmethylphenidate Hcl Er (Focalin Xr) 244
Diazepam 71
Diazepam Intensol 71
Dichlorphenamide 204

Diclegis 292
Diclofenac Epolamine 540
Diclofenac Sodium (Pennsaid) 542
Diclofenac Sodium Gel 3% 538
Dicyclomine Hcl 292
Differin 543
Dihydroergotamine Mesylate Spray 349
Dimethyl Fumarate 356
Dimethyl Fumarate Starterpack 356
Diphenoxylate/Atropine 292
Doptelet 205
Doxepin Hcl 539
Doxylamine Succinate/Pyridoxine Hcl 292
Droxidopa 207
Dupixent 208
Duvyzat 209
Ebglyss 210
Edaravone 211
Elelyso 250
Elidel 58
Eligard 321
Elmiron 212
Eltrombopag 441
Emflaza 203
Emgality 213
Empaveli 214
Emsam 215
Enbrel 94
Enbrel Mini 94
Enbrel Sureclick 94
Endari 322
Enspryng 217
Entyvio Pen 96
Eohilia 218
Epclusa 219
Epidiolex 220
Epogen 223
Ergomar 221
Erivedge 496
Erleada 496
Erlotinib Hcl 496
Esbriet 434
Estazolam 72
Eucrisa 57
Evenity 228
Everolimus 496
Evkeeza 230
Evrysdi 232

Exenatide 156
Exjade 308
Eysuvis 233
Fabhalta 234
Fabior 544
Fanapt 49
Fanapt Pack A 49
Fanapt Pack C 49
Fasenra 236
Fasenra Pen 236
Fentanyl Citrate Oral Transmucosal 237
Fentanyl Patch 397
Ferriprox 202
Ferriprox Twice-A-Day 202
Filspari 238
Filsuvez 239
Fingolimod Hcl 357
Fintepla 240
Fioricet/Codeine 292
Firazyr 282
Firdapse 241
Firmagon 302
Flector 540
Flucytosine 242
Fluphenazine Decanoate 49
Fluphenazine Hcl 49
Flurazepam Hcl 73
Focalin 243
Focalin Xr 244
Forteo 532
Fotivda 496
Fruzaqla 496
Fulphila 169
Fylnetra 170
Gabapentin Once-Daily 253
Galafold 245
Gammagard Liquid 246
Gammagard S/D Iga Less Than 1Mcg/Ml 151
Gammaked 246
Gammaplex 151
Gamunex-C 246
Gattex 248
Gauze Pads 252
Gavreto 496
Gefitinib 496
Genotropin 254
Genotropin Miniquick 254
Geodon 49

Gilenya 357
Gilotrif 496
Glassia 32
Glatiramer Acetate 358
Glatopa 358
Gleevec 496
Gocovri 37
Gomekli 496
Gralise 253
Granix 171
Grastek 415
Hadlima 97
Hadlima Pushtouch 97
Haegarda 280
Haldol Decanoate 100 49
Haloperidol 49
Haloperidol Decanoate 49
Haloperidol Lactate 49
Harvoni 290
Hernexeos 496
Hetlioz 529
Hetlioz Lq 291
Horizant 296
Hulio 98
Humatrope 257
Humira 100
Humira Pen 100
Humira Pen-Cd/Uc/Hs Starter 100
Humira Pen-Pediatric Uc Starter Pack 100
Humira Pen-Ps/Uv Starter 100
Hydrocodone Bitartrate Er 399
Hydromorphone Hcl Er 401
Hydroxyzine Hcl 292
Hydroxyzine Pamoate 292
Hyftor 297
Hyrimoz 102
Hyrimoz Crohn's Disease And Ulcerative Colitis Starter Pack 102
Hyrimoz Pediatric Crohn's Disease Starter Pack 102
Hyrimoz Plaque Psoriasis/Uveitis Starter Pack 102
Hyrimoz Sensoready Pens 102
Hysingla Er 399
Ibrance 496
Ibtrozi 496
Icatibant Acetate 282
Iclusig 496
Idacio 104
Idacio Starter Package For Crohns Disease 104
Idacio Starter Package For Plaque Psoriasis 104

Idhifa 496
Ilumya 106
Imatinib Mesylate 497
Imbruvica 497
Imiquimod Cream 3.75% (Zyclara) 611
Imiquimod Cream 5% 299
Imiquimod Pump 611
Imkeldi 497
Inbrija 300
Ingrezza 301
Inlyta 497
Inqovi 497
Inrebic 497
Insulin Pen Needle 303
Insulin Syringe/Needle 304
Intrarosa 305
Invega 49
Iqirvo 306
Iressa 497
Isotretinoin 310
Isturisa 311
Itovebi 497
Ivabradine Hcl 183
Ivermectin Cream 312
Ivermectin Tablet 313
Iwilfin 497
Jadenu 309
Jadenu Sprinkle 309
Jakafi 497
Jatenzo 314
Javygtor 495
Jaypirca 497
Jaythari 203
Joenja 315
Jornay Pm 316
Jubbonti 317
Juxtapid 294
Jynarque 318
Kalydeco 319
Kerendia 320
Kesimpta 359
Keveyis 204
Kevzara 107
Kineret 109
Kisqali 497
Kisqali Femara 497
Kitabis Pak 537
Korlym 348

Koselugo 497
Krazati 497
Kuvan 495
Lapatinib Ditosylate 497
Latuda 49
Lazcluze 497
Ledipasvir/Sofosbuvir 290
Lenalidomide 497
Lenvima 497
Leqselvi 111
Letairis 445
Leukine 172
Leuprolide Acetate 321
L-glutamine 322
Licart 541
Lidocaine Ointment 323
Lidocaine Patch 324
Lidocaine Solution 325
Lidocaine/Prilocaine 326
Lidocan 324
Linezolid 328
Liraglutide 330
Litfulo 112
Livdelzi 331
Livmarli 333
Lomotil 292
Lonsurf 497
Lorazepam 74
Lorazepam Intensol 74
Lorbrena 497
Loreev Xr 74
Lotronex 30
Loxapine 49
Lumakras 497
Lumryz 334
Lumryz Starter Pack 334
Lupkynis 336
Lupron Depot 321
Lupron Depot-Ped 321
Lurasidone Hcl 49
Lutrate Depot 321
Lybalvi 49
Lynparza 497
Lytgobi 497
Matulane 497
Mavenclad 360
Mavyret 337
Mayzent 361

Mayzent Starter Pack 361
Mekinist 497
Mektovi 497
Memantine Hcl 339
Memantine Hcl Er 338
Memantine Hcl Titration Pak 339
Mepron 60
Metadate Cd 342
Methamphetamine Hcl 340
Methitest 47
Methylin 341
Methylphenidate Hcl (Methylin) 341
Methylphenidate Hcl (Ritalin) 490
Methylphenidate Hcl Cd 342
Methylphenidate Hcl Chewable 343
Methylphenidate Hcl Er (Aptensio Xr) 52
Methylphenidate Hcl Er (Concerta) 182
Methylphenidate Hcl Er (La) Capsule 345
Methylphenidate Hcl Er (Relexxii) 480
Methylphenidate Hcl Er (Ritalin LA) 489
Methylphenidate Hcl Er Tablet 344
Methylphenidate Patch 346
Methyltestosterone 47
Miebo 347
Mifepristone 348
Miglustat 522
Miplyffa 350
Mircera 225
Modafinil 351
Modeyso 497
Molindone Hcl 49
Morphine Sulfate Er 403
Mounjaro 352
Ms Contin 403
Mulpleta 369
Myalept 370
Mycapssa 510
Myfembree 371
Nemluvio 372
Nerlynx 497
Neulasta 173
Neulasta Onpro Kit 173
Neupogen 174
Nexavar 497
Nexletol 374
Nexlizet 376
Ngenla 260
Nilotinib 497

Ninlaro....497
Nivestym....175
Norditropin Flexpro....261
Northera....207
Nourianz....378
Novarel....162
Noxafil....435
Nubeqa....497
Nucala....379
Nucynta Er....409
Nuedexta....380
Nuplazid....381
Nurtec....382
Nutropin Aq Nuspin....264
Nuvigil....56
Nuzyra IV....384
Nuzyra Tablet....385
Nyvepria....176
Octagam....151
Octreotide Acetate....511
Octreotide Kit....513
Odactra....416
Odomzo....497
Ofev....387
Ogsiveo....497
Ohtuvayre....388
Ojemda....497
Ojjaara....497
Olanzapine....49
Olanzapine Odt....49
Olanzapine/Fluoxetine....49
Olpruva....559
Olumiant....113
Omnipod Kit....389
Omnipod Pods....389
Omnitrope....267
Omvoh....115
Onapgo....390
Onfi....69
Onureg....497
Opipza....49
Opsumit....449
Opsynvi....451
Opzelura....413
Orencia....117
Orencia Clickject....117
Orenitram....453
Orenitram Titration Kit....453

Orgovyx 497
Oriahnn 417
Orilissa 418
Orkambi 419
Orladeyo 284
Ormalvi 204
Orserdu 497
Osenvelt 420
Osphena 421
Otezla 422
Otrexup 424
Otulfi 119
Oxazepam 75
Oxervate 425
Oxlumo 426
Oxycodone Hcl Er 405
Oxycontin 405
Oxymorphone Hcl Er 407
Ozempic 427
Palforzia 428
Paliperidone Er 49
Palynziq 429
Panretin 430
Panzyga 431
Pazopanib Hcl 497
Pegasys 433
Pemazyre 497
Pennsaid 542
Perphenazine 49
Pheburane 560
Pimecrolimus 58
Pimozide 49
Piqray 497
Pirfenidone 434
Plegridy 362
Plegridy Starter Pack 362
Pomalyst 497
Ponvory 363
Ponvory 14-Day Starter Pack 363
Posaconazole 435
Posaconazole Dr 435
Praluent 437
Pregnyl 162
Privigen 151
Procrit 223
Procysbi 198
Prolastin-C 33
Prolia 438

Promacta 441
Promethazine Hcl 292
Promethazine Hcl Plain 292
Promethazine Syrup 292
Promethazine Vc 292
Promethazine/Phenylephrine 292
Promethegan 292
Provigil 351
Prudoxin 539
Pyrimethamine 466
Pyrukynd 467
Pyrukynd Taper Pack 467
Pyzchiva 120
Qbrexza 468
Qinlock 498
Quetiapine Fumarate 49
Quetiapine Fumarate Er 49
Quillichew Er 469
Quillivant Xr 470
Quinine Sulfate 471
Qulipta 472
Quviviq 473
Radicava 211
Radicava Ors 211
Radicava Ors Starter Kit 211
Rasuvo 474
Ravicti 561
Rayos 475
Rebif 364
Rebif Rebidose 364
Rebif Rebidose Titration Pack 364
Rebif Titration Pack 364
Reblozyl 476
Recorlev 478
Regranex 479
Releuko 177
Relexxii 480
Relistor Injection 481
Relistor Tablet 482
Repatha 483
Repatha Pushtronex System 483
Repatha Sureclick 483
Retacrit 226
Retevmo 498
Retin-A 545
Retin-A Micro 545
Retin-A Micro Pump 545
Revatio 455

Revcovi 485
Revlimid 498
Revuforj 498
Rexulti 49
Reyvow 486
Rezdiffra 487
Rezlidhia 498
Rezurock 488
Rinvoq Lq 121
Rinvoq Tablet 122
Risperdal 49
Risperidone 49
Risperidone Odt 49
Ritalin 490
Ritalin La 489
Rivfloza 491
Roflumilast 492
Romvimza 498
Rozlytrek 498
Rubraca 498
Ruconest 286
Rybelsus 493
Rydapt 498
Ryvent 292
Sajazir 282
Samsca 494
Sandostatin 511
Sandostatin Lar Depot 513
Saphris 49
Sapropterin Dihydrochloride 495
Scemblix 498
Scopolamine 292
Secuado 49
Selarsdi 123
Sensipar 164
Seroquel 50
Seroquel Xr 50
Serostim 269
Signifor 502
Signifor Lar 501
Sildenafil Citrate 455
Siliq 124
Simlandi 125
Simponi 126
Sivextro 503
Skyclarys 505
Skyrizi 128
Skyrizi Pen 128

Skytrofa 270
Sodium Oxybate 506
Sodium Phenylbutyrate 562
Sofosbuvir/Velpatasvir 219
Sogroya 271
Somatuline Depot 508
Somavert 515
Soolantra 312
Sorafenib 498
Sotyktu 129
Sovaldi 516
Spevigo 517
Sprycel 498
Stelara 130
Steqeyma 131
Stimufend 178
Stivarga 498
Stoboclo 520
Strensiq 518
Stromectol 313
Sucraid 524
Sunitinib Malate 498
Sunosi 525
Sutent 498
Symbyax 50
Symdeko 526
Sympazan 76
Symproic 527
Syprine 548
Tabrecta 498
Tacrolimus 59
Tadalafil 2.5Mg, 5Mg 65
Tadalafil Tablet 20Mg 457
Tadliq 457
Tafinlar 498
Tagrisso 498
Takhzyro 288
Taltz 132
Talzenna 498
Targretin Capsule 498
Targretin Gel 78
Tarpeyo 528
Tascenso Odt 365
Tasigna 498
Tasimelteon 529
Tavalisse 530
Tavneos 531
Tazarotene 544

Tazorac 544
Tazverik 498
Tecfidera 356
Tecfidera Starter Pack 356
Tepmetko 498
Teriflunomide 366
Teriparatide 532
Testim 48
Testosterone 48
Testosterone Cypionate 42
Testosterone Enanthate 44
Testosterone Pump 48
Testosterone Topical Solution 48
Tetrabenazine 534
Thalomid 498
Thioridazine Hcl 50
Thiothixene 50
Tibsovo 498
Tlando 535
Tobi 537
Tobi Podhaler 536
Tobramycin (Bethkis) 77
Tobramycin Neb 537
Tolvaptan (Jynarque) 318
Tolvaptan (Samsca) 494
Torpenz 498
Tracleer 447
Tramadol Hcl Er 411
Trelstar Mixject 547
Tremfya 134
Tretinoin Capsule 498
Tretinoin Cream, Gel 545
Tretinoin Microsphere 545
Tretinoin Microsphere Pump 545
Tridacaine Patch 324
Trientine Hcl 548
Trifluoperazine Hcl 50
Trihexyphenidyl Hcl 292
Trikafta 549
Trudhesa 550
Trulicity 551
Truqap 498
Tryngolza 552
Tryvio 553
Tukysa 498
Turalio 498
Tyenne 136
Tykerb 498

Tymlos 554
Tyrvaya 556
Tyvaso Dpi 459
Ubrelvy 557
Uceris 155
Udenyca 179
Udenyca Onbody 179
Undecatrex 558
Uptravi 460
Uptravi Titration Pack 460
Ustekin-Aekn 123
Ustekin-Ttwe 120
Ustekinumab 130
Valchlor 563
Valium 71
Vanflyta 498
Vanrafia 565
Velsipity 138
Venclexta 498
Venclexta Starting Pack 498
Ventavis 462
Veozah 566
Verkazia 392
Versacloz 50
Verzenio 498
Vevye 393
Vfend 571
Vfend Iv 571
V-Go 567
Viberzi 568
Victoza 330
Vijoice 569
Vitrakvi 498
Vivjoa 570
Vizimpro 498
Vogelxo 48
Vogelxo Pump 48
Vonjo 498
Voranigo 498
Voriconazole 571
Vosevi 573
Votrient 498
Vowst 574
Voxzogo 575
Voydeya 576
Vpriv 251
Vtama 577
Vumerity 367

Vykat XR 579
Vyndamax 580
Vyndaqel 581
Vyvgart Hytrulo 582
Wainua 583
Wakix 584
Wegovy 585
Welireg 498
Wezlana 139
Winlevi 586
Winrevair 464
Wyost 587
Xalkori 498
Xdemvy 588
Xeljanz Solution 140
Xeljanz Tablet 141
Xeljanz Xr 143
Xembify 589
Xenazine 534
Xermelo 590
Xgeva 591
Xifaxan 200Mg 593
Xifaxan 550Mg 594
Xiidra 394
Xolair 595
Xolremdi 598
Xospata 498
Xpovio 498
Xtampza Er 405
Xtandi 499
Xyosted 46
Xyrem 506
Xywav 599
Yargesa 522
Yesintek 145
Yonsa 499
Yorvipath 601
Yuflyma Cd/Uc/Hs Starter 146
Yuflyma Kit 146
Yusimry 148
Yutrepia 465
Zarxio 180
Zavesca 522
Zavzpret 602
Zejula 499
Zelboraf 499
Zelsuvmi 603
Zemaira 31

Zenatane 310
Zepatier 604
Zepbound 605
Zeposia 368
Zeposia 7-Day Starter Pack 368
Zeposia Starter Kit 368
Ziextenzo 181
Zilbrysq 606
Ziprasidone Mesylate 50
Zolinza 499
Zomacton 273
Zonalon 539
Zoryve Cream 0.15% 607
Zoryve Cream 0.3% 608
Zoryve Foam 609
Zovirax 24
Ztalmy 610
Ztlido 327
Zyclara 611
Zyclara Pump 611
Zydelig 499
Zykadia 499
Zymfentra 149
Zyprexa 50
Zyprexa Zydis 50
Zytiga 499
Zyvox 328

Prior Authorization Group Description:
Absorica LD PA
Drug Name(s)
Absorica Ld
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. Patient has an FDA labeled indication or 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
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal
Other Criteria:

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:
Approval will be 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 (Hadlima)] 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:
Adbry PA
Drug Name(s)
Adbry
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 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., 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 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 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:
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:
Agamree PA
Drug Name(s)
Agamree
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 Duchenne muscular dystrophy (DMD) confirmed by ONE of the following:
    A. Presence of abnormal dystrophin OR
    B. Confirmed mutation of the dystrophin 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 Duchenne muscular dystrophy (DMD) AND
3. Patient has had improvement, stabilization of the disease, or clinical benefit from baseline (e.g., slowed disease progression, improved strength and timed motor function, improved pulmonary function, reduced the need for scoliosis surgery)
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:
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 or more migraine headache days per month AND
4. 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 or more migraine headache days per month AND
4. 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:
Alcohol Swabs PA
Drug Name(s)
Alcohol Swabs
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
This program will be implemented as a dynamic PA.
Criteria for approval require BOTH of the following:
1. The requested medical supply product will be used in the delivery of insulin to the body AND
2. Patient's medication history includes use of insulin within the past 180 days
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Alosetron PA
Drug Name(s)
Alosetron Hcl
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/Zemaira
Drug Name(s)
Aralast Np
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:
Alpha-1-Proteinase Inhibitor PA – Prolastin-C
Drug Name(s)
Prolastin-C
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:

Alvaiz PA

Drug Name(s)

Alvaiz

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 persistent or chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following:
        - i. Patient has tried and had an insufficient response to a corticosteroid or immunoglobulin (IVIg or anti-D) OR
        - ii. Patient has an intolerance or hypersensitivity to a corticosteroid or immunoglobulin (IVIg or anti-D) OR
        - iii. Patient has an FDA labeled contraindication to a corticosteroid or immunoglobulin (IVIg or anti-D) OR
        - iv. Patient has had an insufficient response to a splenectomy OR
    - B. Patient has a diagnosis of hepatitis C associated thrombocytopenia AND ONE of the following:
        - i. Patient's platelet count is less than 75 x 10^9/L AND the intent is to increase platelet counts sufficiently to initiate interferon therapy OR
        - ii. Patient is on concomitant therapy with interferon therapy AND is at risk for discontinuing hepatitis C therapy due to thrombocytopenia OR
    - C. Patient has a diagnosis of severe aplastic anemia (SAA) AND ALL of the following:
        - i. Patient has at least 2 of the following blood criteria:
            1. Neutrophils less than 0.5 X 10^9/L OR
            2. Platelets less than 30 X 10^9/L OR
            3. Reticulocyte count less than 60 X 10^9/L AND
        - ii. Patient has at least 1 of the following marrow criteria:
            1. Severe hypocellularity is less than 25% OR
            2. Moderate hypocellularity is 25-50% with hematopoietic cells representing less than 30% of residual cells AND
        - iii. Patient has tried and had an insufficient response to BOTH antithymocyte globulin (ATG) AND cyclosporine therapy OR
    - D. 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:

Initial: 6 months for ITP. Renewal: 12 months for ITP. Other indications, see Other Criteria.

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 persistent or 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 OR
    B. Patient has a diagnosis of hepatitis C associated thrombocytopenia AND BOTH of the following:
        i. ONE of the following:
            1. Patient will be initiating hepatitis C therapy with interferon therapy OR
            2. Patient will be maintaining hepatitis C therapy with interferon therapy at the same time as the requested agent AND
        ii. ONE of the following:
            1. Patient's platelet count is 90 x 10^9/L or greater OR
            2. Patient's platelet count has increased sufficiently to initiate or maintain interferon therapy for the treatment of hepatitis C OR
    C. Patient has a diagnosis of severe aplastic anemia (SAA) AND the patient has had clinical benefit with the requested agent OR
    D. Patient has another indication that is supported in CMS approved compendia AND the patient has had clinical benefit with the requested agent AND
3. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Initial: 48 weeks for hepatitis C associated thrombocytopenia, 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:
Alyftrek PA
Drug Name(s)
Alyftrek
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. Patient has at least one F508del mutation or another responsive mutation in the CFTR gene 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:
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:
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 the testing laboratory's normal range 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 the testing laboratory's normal range 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 – Azmiro
Drug Name(s)
Azmiro
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 the testing laboratory's normal range 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 the testing laboratory's normal range 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 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 the testing laboratory's normal range 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 the testing laboratory's normal range 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 the testing laboratory's normal range 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 the testing laboratory's normal range 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:
Pending CMS Review

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 the testing laboratory's normal range 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 the testing laboratory's normal range 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)
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:
Pending CMS Review

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 Hcl
Clozapine
Clozapine Odt
Clozaril
Fanapt
Fanapt Pack A
Fanapt Pack C
Fluphenazine Decanoate
Fluphenazine Hcl
Geodon
Haldol Decanoate 100
Haloperidol
Haloperidol Decanoate
Haloperidol Lactate
Invega
Latuda
Loxapine
Lurasidone Hcl
Lybalvi
Molindone Hcl
Olanzapine
Olanzapine Odt
Olanzapine/Fluoxetine
Opipza
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 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 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 Hcl
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. 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)
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 Hcl Er (Aptensio 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:
Aqneursa PA
Drug Name(s)
Aqneursa
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 Niemann-Pick disease Type C (NPC) as confirmed by genetic analysis mutation in the NPC1 or NPC2 genes AND
2. The requested agent will be used for the treatment of neurological manifestations of Niemann-Pick disease type C (NPC)

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 Niemann-Pick disease Type C (NPC) AND
3. The requested agent will be used for the treatment of neurological manifestations of Niemann-Pick disease type C (NPC) 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., endocrinologist, geneticist, hepatologist, gastroenterologist, 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:
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:
Pending CMS 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:
Attruby PA
Drug Name(s)
Attruby
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 variant transthyretin-mediated amyloidosis (ATTR-CM) AND
2. The diagnosis has been confirmed by testing [e.g., stannous pyrophosphate (PYP) scanning, monoclonal antibody studies, biopsy, scintigraphy, genetic testing (TTR genotyping)] AND
3. The requested agent will be used to reduce cardiovascular death and cardiovascular-related hospitalization AND
4. Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure AND
5. Patient has clinical manifestations of cardiomyopathy (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema) AND
6. Patient will NOT be using the requested agent in combination with Amvuttra or a 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 variant transthyretin-mediated amyloidosis (ATTR-CM) AND
3. The requested agent will be used to reduce cardiovascular death and cardiovascular-related hospitalization AND
4. Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure AND
5. Patient has had clinical benefit with the requested agent AND
6. Patient will NOT be using the requested agent in combination with Amvuttra or a 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:
Austedo PA
Drug Name(s)
Austedo
Austedo Xr
Austedo Xr Patient 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 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 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 ONLY 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. Patient has tried and had an insufficient response, intolerance or hypersensitivity, or 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 SC PA
Drug Name(s)
Benlysta SC
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Benzodiazepines PA - Chlordiazepoxide
Drug Name(s)
Chlordiazepoxide Hcl
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 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:
PA does NOT apply to patients less than 65 years of age.
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. 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. 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:
PA does NOT apply to patients less than 65 years of age.
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:
PA does NOT apply to patients less than 65 years of age.
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:
PA does NOT apply to patients less than 65 years of age.
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 FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require the following:
1. Patient has a diagnosis of insomnia
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Benzodiazepines PA – Flurazepam
Drug Name(s)
Flurazepam Hcl
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require the following:
1. Patient has a diagnosis of insomnia
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:
PA does NOT apply to patients less than 65 years of age.
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:
PA does NOT apply to patients less than 65 years of age.
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:
PA does NOT apply to patients less than 65 years of age.
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) OR
    b. Patient is currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam) 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. 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. 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. 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 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 – Abrilada
Drug Name(s)
Abrilada
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 ONE preferred agent (Hadlima or Simlandi) is required for diagnoses of juvenile idiopathic arthritis, rheumatoid arthritis, pediatric Crohn's disease, or uveitis

Use of TWO preferred agents (Cosentyx, Hadlima, or Simlandi) is required for diagnoses of ankylosing spondylitis or hidradenitis suppurativa

Use of TWO preferred agents (Hadlima, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of adult Crohn's disease or ulcerative colitis

Use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of plaque psoriasis or psoriatic arthritis

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

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 (Hadlima, Rinvoq tablets, Rinvoq solution, or Simlandi) is required for diagnosis of polyarticular juvenile idiopathic arthritis

Use of TWO preferred agents (Hadlima, Rinvoq tablets, or Simlandi) is required for diagnosis of rheumatoid arthritis

Use of ONE preferred agent (Rinvoq tablets) is required for diagnosis of giant cell arteritis

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

Prior Authorization Group Description:
Biologic Immunomodulators PA – Amjevita
Drug Name(s)
Amjevita
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 ONE preferred agent (Hadlima or Simlandi) is required for diagnoses of juvenile idiopathic arthritis, rheumatoid arthritis, pediatric Crohn's disease, or uveitis

Use of TWO preferred agents (Cosentyx, Hadlima, or Simlandi) is required for diagnoses of ankylosing spondylitis or hidradenitis suppurativa

Use of TWO preferred agents (Hadlima, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of adult Crohn's disease or ulcerative colitis

Use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of plaque psoriasis or psoriatic arthritis

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

Prior Authorization Group Description:
Biologic Immunomodulators PA – Bimzelx
Drug Name(s)
Bimzelx
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, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Rinvoq tablets, Rinvoq solution, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Hadlima, Rinvoq tablets, or Simlandi) is required for diagnosis of ankylosing spondylitis

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

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

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 ONE preferred agent (Hadlima or Simlandi) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cosentyx, Hadlima, or Simlandi) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Hadlima, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of Crohn's disease

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

Use of ONE preferred agent (Hadlima or Simlandi) is required for diagnosis of juvenile idiopathic arthritis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Cosentyx
Drug Name(s)
Cosentyx
Cosentyx Sensoready Pen
Cosentyx Unoready
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 diagnosis of plaque psoriasis

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

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 Starter Package For Crohns Disease/Uc/Hs
Cyltezo Starter Package For Psoriasis
Cyltezo Starter Package For Psoriasis/Uveitis
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 ONE preferred agent (Hadlima or Simlandi) is required for diagnoses of juvenile idiopathic arthritis, rheumatoid arthritis, pediatric Crohn's disease, or uveitis

Use of TWO preferred agents (Cosentyx, Hadlima, or Simlandi) is required for diagnoses of ankylosing spondylitis or hidradenitis suppurativa

Use of TWO preferred agents (Hadlima, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of adult Crohn's disease or ulcerative colitis

Use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of plaque psoriasis or psoriatic arthritis

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

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. 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 ONE preferred agent (Hadlima or Simlandi) is required for diagnoses of ankylosing spondylitis, psoriatic arthritis, adult plaque psoriasis, polyarticular juvenile idiopathic arthritis, or rheumatoid arthritis

NO preferred agent is required for diagnoses of juvenile psoriatic arthritis or pediatric plaque psoriasis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Entyvio SC
Drug Name(s)
Entyvio Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA – Hadlima
Drug Name(s)
Hadlima
Hadlima Pushtouch
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA – Hulio
Drug Name(s)
Adalimumab-Fkjp
Hulio
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 ONE preferred agent (Hadlima or Simlandi) is required for diagnoses of juvenile idiopathic arthritis, rheumatoid arthritis, pediatric Crohn's disease, or uveitis

Use of TWO preferred agents (Cosentyx, Hadlima, or Simlandi) is required for diagnoses of ankylosing spondylitis or hidradenitis suppurativa

Use of TWO preferred agents (Hadlima, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of adult Crohn's disease or ulcerative colitis

Use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of plaque psoriasis or psoriatic arthritis

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

Prior Authorization Group Description:
Biologic Immunomodulators PA – Humira
Drug Name(s)
Humira
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. 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 ONE preferred agent (Hadlima or Simlandi) is required for diagnoses of juvenile idiopathic arthritis, rheumatoid arthritis, pediatric Crohn's disease, or adult uveitis

Use of TWO preferred agents (Cosentyx, Hadlima, or Simlandi) is required for diagnoses of ankylosing spondylitis or adult hidradenitis suppurativa

Use of TWO preferred agents (Hadlima, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of adult Crohn's disease or adult ulcerative colitis

Use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of plaque psoriasis or psoriatic arthritis

NO preferred agent is required for diagnoses of adult fistulizing Crohn's disease, pediatric hidradenitis suppurativa, pediatric ulcerative colitis, or pediatric uveitis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Hyrimoz
Drug Name(s)
Adalimumab-Adaz
Hyrimoz
Hyrimoz Crohn's Disease And Ulcerative Colitis Starter Packk
Hyrimoz Pediatric Crohn's Disease Starter Pack
Hyrimoz Plaque Psoriasis/Uveitis Starter Pack
Hyrimoz Sensoready Pens
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 ONE preferred agent (Hadlima or Simlandi) is required for diagnoses of juvenile idiopathic arthritis, rheumatoid arthritis, pediatric Crohn's disease, or uveitis

Use of TWO preferred agents (Cosentyx, Hadlima, or Simlandi) is required for diagnoses of ankylosing spondylitis or hidradenitis suppurativa

Use of TWO preferred agents (Hadlima, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of adult Crohn's disease or ulcerative colitis

Use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of plaque psoriasis or psoriatic arthritis

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

Prior Authorization Group Description:
Biologic Immunomodulators PA – Idacio
Drug Name(s)
Adalimumab-Aacf
Adalimumab-Aacf Starter Pack/Cd/Uc/Hs (6 Pen)
Adalimumab-Aacf Starter Pack/Psoriasis/Uveitis (4 Pen)
Idacio
Idacio Starter Package For Crohns Disease
Idacio Starter Package For Plaque Psoriasis
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 ONE preferred agent (Hadlima or Simlandi) is required for diagnoses of juvenile idiopathic arthritis, rheumatoid arthritis, pediatric Crohn's disease, or uveitis

Use of TWO preferred agents (Cosentyx, Hadlima, or Simlandi) is required for diagnoses of ankylosing spondylitis or hidradenitis suppurativa

Use of TWO preferred agents (Hadlima, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of adult Crohn's disease or ulcerative colitis

Use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of plaque psoriasis or psoriatic arthritis

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

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, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of plaque psoriasis

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 (Hadlima, Rinvoq tablets, or Simlandi) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Hadlima, Rinvoq tablets, Rinvoq solution, or Simlandi) is required for diagnosis of juvenile idiopathic 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 (Hadlima, Rinvoq tablets, or Simlandi) 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 – Leqselvi
Drug Name(s)
Leqselvi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

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:

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 (Hadlima, Rinvoq tablets, or Simlandi) is required for diagnosis of rheumatoid arthritis

NO preferred agent is required for diagnosis of alopecia areata

Prior Authorization Group Description:
Biologic Immunomodulators PA – Omvoh
Drug Name(s)
Omvoh
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 (Hadlima, Rinvoq tablets, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of ulcerative colitis

Use of TWO preferred agents (Hadlima, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of Crohn’s disease

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 (Hadlima, Rinvoq tablets, Rinvoq solution, or Simlandi) is required for diagnosis of juvenile idiopathic arthritis

Use of TWO preferred agents (Hadlima, Rinvoq tablets, or Simlandi) is required for diagnosis of rheumatoid arthritis

For patients 18 years of age or over, use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Rinvoq tablets, Rinvoq solution, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of psoriatic arthritis

For patients between 6 and less than 18 years of age, use of ONE preferred agent (Cosentyx) is required for diagnosis of psoriatic arthritis

For patients between 2 and less than 6 years of age, NO preferred agent 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 – Otulfi
Drug Name(s)
Otulfi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA – Pyzchiva
Drug Name(s)
Pyzchiva
Ustekin-Ttwe
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA – Rinvoq Solution
Drug Name(s)
Rinvoq Lq
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) OR
        iv. The request is for an FDA labeled indication that is not covered by 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 (Hadlima or Simlandi) is required for diagnoses of adult psoriatic arthritis or juvenile idiopathic arthritis

NO preferred TNF agent is required for diagnosis of pediatric psoriatic arthritis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Rinvoq Tablet
Drug Name(s)
Rinvoq Tablet
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA – Selarsdi
Drug Name(s)
Selarsdi
Ustekin-Aekn
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

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, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of plaque psoriasis

Prior Authorization Group Description:
Biologic Immunomodulators PA - Simlandi
Drug Name(s)
Simlandi
Indications:
All FDA-Approved Indications
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

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 ONE preferred agent (Hadlima or Simlandi) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Cosentyx, Hadlima, or Simlandi) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Hadlima, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of ulcerative colitis

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:
Pending CMS Review

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, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of plaque psoriasis

Prior Authorization Group Description:
Biologic Immunomodulators PA – Stelara
Drug Name(s)
Stelara
Ustekinumab
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA – Steqeyma
Drug Name(s)
Steqeyma
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

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, Hadlima, Otezla, Rinvoq tablets, Rinvoq solution, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of psoriatic arthritis

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

For patients between 6 and less than 18 years of age, use of TWO preferred agents (Cosentyx, Stelara, or Steqeyma) is required for diagnosis of plaque psoriasis

Use of TWO preferred agents (Cosentyx, Hadlima, Rinvoq tablets, or Simlandi) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Cosentyx and Rinvoq tablets) 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 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 plaque psoriasis or Crohn's disease

NO prerequisites are required for diagnoses of psoriatic arthritis, moderate ulcerative colitis, or severe ulcerative colitis

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

Prior Authorization Group Description:
Biologic Immunomodulators PA - Tyenne
Drug Name(s)
Tyenne
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 (Hadlima, Rinvoq tablets, Rinvoq solution, or Simlandi) is required for diagnosis of polyarticular juvenile idiopathic arthritis

Use of TWO preferred agents (Hadlima, Rinvoq tablets, or Simlandi) is required for diagnosis of rheumatoid arthritis

Use of ONE preferred agent (Rinvoq tablets) is required for diagnosis of giant cell arteritis

NO preferred agent is required for diagnoses of cytokine release syndrome or systemic juvenile idiopathic arthritis

Prior Authorization Group Description:
Biologic Immunomodulators PA - Velsipity
Drug Name(s)
Velsipity
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 (Hadlima, Rinvoq tablets, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of ulcerative colitis

Prior Authorization Group Description:
Biologic Immunomodulators PA - Wezlana
Drug Name(s)
Wezlana
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

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. 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 (Hadlima, Rinvoq tablets, Rinvoq solution, or Simlandi) 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. 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, Hadlima, Otezla, Rinvoq tablets, Rinvoq solution, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Hadlima, Rinvoq tablets, or Simlandi) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Hadlima, Rinvoq tablets, Rinvoq solution, or Simlandi) is required for diagnosis of juvenile idiopathic arthritis

Use of TWO preferred agents (Cosentyx, Hadlima, Rinvoq tablets, or Simlandi) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Hadlima, Rinvoq tablets, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) 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. 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, Hadlima, Otezla, Rinvoq tablets, Rinvoq solution, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of psoriatic arthritis

Use of TWO preferred agents (Hadlima, Rinvoq tablets, or Simlandi) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred agents (Cosentyx, Hadlima, Rinvoq tablets, or Simlandi) is required for diagnosis of ankylosing spondylitis

Use of TWO preferred agents (Hadlima, Rinvoq tablets, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of ulcerative colitis

Prior Authorization Group Description:
Biologic Immunomodulators PA - Yesintek
Drug Name(s)
Yesintek
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Yuflyma
Drug Name(s)
Adalimumab-Aaty Cd/Uc/Hs Starter
Adalimumab-Aaty Kit
Yuflyma Cd/Uc/Hs Starter
Yuflyma 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 ONE preferred agent (Hadlima or Simlandi) is required for diagnoses of juvenile idiopathic arthritis, rheumatoid arthritis, pediatric Crohn's disease, or uveitis

Use of TWO preferred agents (Cosentyx, Hadlima, or Simlandi) is required for diagnoses of ankylosing spondylitis or hidradenitis suppurativa

Use of TWO preferred agents (Hadlima, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of adult Crohn's disease or ulcerative colitis

Use of TWO preferred agents (Cosentyx, Hadlima, Otezla, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnoses of plaque psoriasis or psoriatic arthritis

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

Prior Authorization Group Description:
Biologic Immunomodulators PA - Yusimry
Drug Name(s)
Yusimry
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Zymfentra
Drug Name(s)
Zymfentra
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 (Hadlima, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of adult Crohn's disease

Use of TWO preferred agents (Hadlima, Simlandi, Skyrizi, Stelara, Steqeyma, or Tremfya) is required for diagnosis of ulcerative colitis

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

Prior Authorization Group Description:
Bivigam/Flebogamma/Gammagard SD/Gammaplex/Octagam/Privigen PA
Drug Name(s)
Bivigam
Gammagard S/D Iga Less Than 1Mcg/Ml
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., mycophenolate)] 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., Enbrel), 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, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Kesimpta, Plegridy, teriflunomide, Vumerity) OR

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

i. Patient has failed ONE conventional therapy (e.g., desmopressin, von Willebrand factor replacement therapy, corticosteroids, 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:
Bomyntra PA
Drug Name(s)
Bomyntra
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Budesonide Oral ER PA – Entocort
Drug Name(s)
Budesonide Dr (Entocort)
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)
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:
Byetta PA
Drug Name(s)
Exenatide
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 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 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR
    C. ALL of the following:
        i. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND
        iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor
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 tobramycin) OR
    b. Patient is currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., 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 ONLY 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., 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:
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, 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 Hcl
Sensipar
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:
    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:
Cobenfy PA
Drug Name(s)
Cobenfy
Cobenfy Starter Pack
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 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 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Prescriber has assessed the patient's liver enzymes and bilirubin prior to starting therapy with the requested agent AND
        ii. Prescriber has assessed the patient's heart rate prior to starting therapy with the requested agent AND
        iii. ONE of the following:
            a. Patient has tried and had an inadequate response to TWO antipsychotic agents (e.g., aripiprazole, haloperidol, loxapine, olanzapine, quetiapine, risperidone) for the requested indication OR
            b. Patient has an intolerance or hypersensitivity to TWO antipsychotic agents (e.g., aripiprazole, haloperidol, loxapine, olanzapine, quetiapine, risperidone) OR
            c. Patient has an FDA labeled contraindication to TWO antipsychotic agents (e.g., aripiprazole, haloperidol, loxapine, olanzapine, quetiapine, risperidone) AND
        iv. 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. Patient has an FDA labeled indication 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. Prescriber has assessed the patient's liver enzymes and bilirubin as clinically indicated during treatment with the requested agent AND

ii. Prescriber has assessed the patient's heart rate as clinically indicated during treatment with the requested agent AND

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

iv. Patient has had clinical benefit with the requested agent

Prior Authorization Group Description:
Conexxence PA
Drug Name(s)
Conexxence
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:
Pending CMS Review

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 – 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
Udenyca Onbody
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 Hcl 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
Ivabradine Hcl
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 following:
    A. ALL of the following:
        i. Patient has stable, symptomatic heart failure (e.g., NYHA Class II, III, IV: ACCF/AHA Class C, D) due to dilated cardiomyopathy (DCM) AND
        ii. The requested agent is for a pediatric patient, 6 months of age or over AND
        iii. Patient is in sinus rhythm with an elevated heart rate OR
    B. ALL of the following:
        i. Patient has stable, symptomatic chronic heart failure (e.g., NYHA Class II, III, IV: ACCF/AHA Class C, D) AND
        ii. The requested agent is for an adult patient AND
        iii. Patient has a baseline OR current left ventricular ejection fraction of 35% or less AND
        iv. 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
        v. ONE of the following:
            a. Patient is on a maximally tolerated dose of beta blocker (e.g., bisoprolol, carvedilol, metoprolol) OR
            b. 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 (Hadlima)] 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:
Crenessity PA
Drug Name(s)
Crenessity
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

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 or invasive mucormycosis and patient has continued indicators of active disease (e.g., biomarkers in serum assay, microbiologic culture, radiographic evidence) OR
    B. 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:
Crotan PA
Drug Name(s)
Crotan
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 2 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, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Kesimpta, 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:
Pending CMS Review

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. Patient has a diagnosis of transfusional iron overload due to thalassemia syndromes, 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:
Deflazacort PA
Drug Name(s)
Deflazacort
Emflaza
Jaythari
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., slowed disease progression, 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:
Dichlorphenamide PA
Drug Name(s)
Dichlorphenamide
Keveyis
Ormalvi
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 BOTH of the following:
1. 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 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 has tried and had an insufficient response to a corticosteroid, another thrombopoietin receptor agonist (e.g., Promacta), or immunoglobulin (IVIg or anti-D) OR
        ii. Patient has an intolerance or hypersensitivity to a corticosteroid, another thrombopoietin receptor agonist (e.g., Promacta), or immunoglobulin (IVIg or anti-D) OR
        iii. Patient has an FDA labeled contraindication to a corticosteroid, another thrombopoietin receptor agonist (e.g., Promacta), or immunoglobulin (IVIg or anti-D) OR
        iv. Patient has had an insufficient response to a splenectomy AND
2. The requested dose is within FDA labeled dosing for the requested indication
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 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 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 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 AND

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

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:
Pending CMS Review

Prior Authorization Group Description:
Duvyzat PA
Drug Name(s)
Duvyzat
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 Duchenne muscular dystrophy (DMD) confirmed by ONE of the following:
    A. Presence of abnormal dystrophin OR
    B. Confirmed mutation of the dystrophin 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 Duchenne muscular dystrophy (DMD) AND
3. Patient has had improvement, stabilization of the disease, or clinical benefit from baseline (e.g., slowed disease progression, improved strength and timed motor function, improved pulmonary function, reduced the need for scoliosis surgery)
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:
Ebglyss PA
Drug Name(s)
Ebglyss
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., 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 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 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:
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:
Edaravone PA
Drug Name(s)
Edaravone
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) or slow vital capacity (SVC) 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:
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:
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 or more migraine headache days per month 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 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:
Empaveli PA
Drug Name(s)
Empaveli
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

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 BOTH 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., selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), mirtazapine, bupropion) OR
                    2. Patient has an intolerance or hypersensitivity to at least two different oral antidepressants (e.g., selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), mirtazapine, bupropion) OR
                    3. Patient has an FDA labeled contraindication to at least two different oral antidepressants (e.g., selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (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:
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:
Eohilia PA
Drug Name(s)
Eohilia
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 eosinophilic esophagitis (EoE) confirmed by esophageal biopsy 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., allergist, gastroenterologist, immunologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 3 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. 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 the preferred agent: Mavyret 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 the preferred agent: Mavyret 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:
Ergomar PA
Drug Name(s)
Ergomar
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

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 (there must be a minimum of 2 additional months of planned 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:
Approval will be 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 less than or equal to 13 g/dL 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 (there must be a minimum of 2 additional months of planned 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 – Mircera
Drug Name(s)
Mircera
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS 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 less than or equal to 13 g/dL 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 (there must be a minimum of 2 additional months of planned 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 lower limit of the testing laboratory's normal range OR
B. Patient has a pretreatment or current calcium level that is below the lower limit 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. Patient's diagnosis was confirmed by ONE of the following:
    A. Genetic confirmation of bi-allelic pathogenic/likely pathogenic variants on different chromosomes at the LDLR, Apo-B, PCSK9, or LDLRAP1 genes or greater than or equal to 2 such variants at different loci OR
    B. History of untreated LDL-C greater than 400 mg/dL (greater than 10 mmol/L) AND ONE of the following:
        i. Patient has cutaneous or tendon xanthomas before the age of 10 years OR
        ii. Untreated elevated LDL-C levels consistent with heterozygous familial hypercholesterolemia (HeFH) in both parents (or in digenic form, one parent may have normal LDL-C levels and the other may have LDL-C levels consistent with HoFH) 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 BOTH of the following:
1. Patient has a diagnosis of Spinal Muscular Atrophy (SMA) AND
2. Patient has a deletion or mutation at the survival motor neuron 1 (SMN1) gene on chromosome 5q 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:
Fabhalta PA
Drug Name(s)
Fabhalta
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 paroxysmal nocturnal hemoglobinuria (PNH) OR
    B. ALL of the following:
        i. Patient has a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy AND
        ii. The requested agent will be used to reduce proteinuria AND
        iii. 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 0.44 g/g OR
            b. Proteinuria greater than or equal to 0.5 g/day AND
        iv. ONE of the following:
            a. Patient has tried and had an inadequate response with a maximally tolerated angiotensin-converting-enzyme inhibitor (ACEI) [e.g., benazepril, lisinopril], or angiotensin II blocker (ARB) [e.g., losartan], or a combination medication containing an ACEI or ARB OR
            b. Patient has an intolerance or hypersensitivity to an ACEI or ARB, or a combination medication containing an ACEI or ARB OR
            c. Patient has an FDA labeled contraindication to an ACEI or ARB, or a combination medication containing an ACEI or ARB OR
    C. ALL of the following:
        i. Patient has a diagnosis of complement 3 glomerulopathy (C3G) confirmed by kidney biopsy AND
        ii. The requested agent will be used to reduce proteinuria AND
        iii. ONE of the following:
            a. Patient has a urine protein to creatinine ratio (UPCR) greater than or equal to 0.8 g/g OR
            b. Patient has a proteinuria greater than or equal to 1 g/day AND

Initial criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., hematologist, 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:

iv. ONE of the following:

a. Patient has tried and had an inadequate response with a maximally tolerated angiotensin-converting-enzyme inhibitor (ACEI) [e.g., benazepril, lisinopril], or angiotensin II blocker (ARB) [e.g., losartan], or a combination medication containing an ACEI or ARB OR

b. Patient has an intolerance or hypersensitivity to an ACEI or ARB, or a combination medication containing an ACEI or ARB OR

c. Patient has an FDA labeled contraindication to an ACEI or ARB, or a combination medication containing an ACEI or ARB

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 Paroxysmal Nocturnal Hemoglobinuria (PNH) OR
   - B. BOTH of the following:
     - i. Patient has a diagnosis of primary immunoglobulin A nephropathy (IgAN) AND
     - ii. The requested agent will be used to reduce proteinuria OR
   - C. BOTH of the following:
     - i. Patient has a diagnosis of complement 3 glomerulopathy (C3G) AND
     - ii. The requested agent will be used to reduce proteinuria AND
3. Patient has had clinical benefit with the requested agent

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:
Pending CMS Review

Prior Authorization Group Description:
Fentanyl Oral PA - Fentanyl lozenge
Drug Name(s)
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 BOTH of the following:
        i. Prescriber has provided the patient's type of cancer AND
        ii. 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 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:
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 slow kidney function decline AND
3. Patient is at risk of disease progression as shown by ONE of the following:
    A. A urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.44 g/g OR
    B. Proteinuria greater than or equal to 0.5 g/day AND
4. ONE of the following:
    A. Patient has tried and had an inadequate response with a maximally tolerated angiotensin-converting-enzyme inhibitor (ACEI) [e.g., benazepril, lisinopril], or angiotensin II blocker (ARB) [e.g., losartan], or a combination medication containing an ACEI or ARB OR
    B. Patient has an intolerance or hypersensitivity to an ACEI or ARB, or a combination medication containing an ACEI or ARB, that is not expected to occur with the requested agent OR
    C. Patient has an FDA labeled contraindication to an ACEI or ARB, or a combination medication containing an ACEI 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 slow kidney function decline 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:
Filsuvez PA
Drug Name(s)
Filsuvez
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

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. Neurophysiology study (e.g., nerve conduction studies [CMAP], EMG, repetitive stimulation) OR
    B. Anti-P/Q-type voltage-gated calcium channels (VGCC) 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 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, oncologist) 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:
Flucytosine PA
Drug Name(s)
Ancobon
Flucytosine
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 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. The requested agent will be used in combination with amphotericin B OR
    B. Prescriber has provided information in support of therapy without concurrent amphotericin B for the requested indication 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:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 10 weeks
Other Criteria:

Prior Authorization Group Description:
Focalin PA
Drug Name(s)
Dexmethylphenidate Hcl (Focalin)
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 Hcl Er (Focalin Xr)
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

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
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:
Gammagard/Gammaked/Gamunex-C PA
Drug Name(s)
Gammagard Liquid
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., mycophenolate)] 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., Enbrel), 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, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Kesimpta, Plegridy, teriflunomide, Vumerity) OR

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

i. Patient has failed ONE conventional therapy (e.g., desmopressin, von Willebrand factor replacement therapy, corticosteroids, 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 clinical benefit with the requested agent [e.g., 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 (prior to therapy for the requested indication) 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 glucocerebrosidase (GBA) gene with two disease-causing alleles AND
2. 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 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 Gaucher disease type 1 (GD1) 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., endocrinologist, geneticist, hematologist, hepatologist, 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 (prior to therapy for the requested indication) 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 glucocerebrosidase (GBA) gene with two disease-causing alleles AND
2. 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 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 Gaucher disease type 1 (GD1) 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., endocrinologist, geneticist, hematologist, hepatologist, 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 (prior to therapy for the requested indication) 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 glucocerebrosidase (GBA) gene with two disease-causing alleles AND
2. 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 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 Gaucher disease type 1 (GD1) 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., endocrinologist, geneticist, hematologist, hepatologist, 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:
Gauze Pads PA
Drug Name(s)
Gauze Pads
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
This program will be implemented as a dynamic PA.
Criteria for approval require BOTH of the following:
1. The requested medical supply product will be used in the delivery of insulin to the body AND
2. Patient's medication history includes use of insulin within the past 180 days
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Gralise PA
Drug Name(s)
Gabapentin Once-Daily
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
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 – 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:
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-nl-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 – 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. 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 the preferred agent: Mavyret 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 the preferred agent: Mavyret 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
Bonjesta
Butalbital/Acetaminophen/Caffeine/Codeine
Butalbital/Aspirin/Caffeine/Codeine
Carbinoxamine Maleate
Clemastine Fumarate
Cyproheptadine Hcl
Diclegis
Dicyclomine Hcl
Diphenoxylate/Atropine
Doxylamine Succinate/Pyridoxine Hcl
Fioricet/Codeine
Hydroxyzine Hcl
Hydroxyzine Pamoate
Lomotil
Promethazine Hcl Plain
Promethazine Hcl
Promethazine Syrup
Promethazine Vc
Promethazine/Phenylephrine
Promethegan
Ryvent
Scopolamine
Trihexyphenidyl Hcl
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. Patient's diagnosis was confirmed by ONE of the following:
    A. Genetic confirmation of bi-allelic pathogenic/likely pathogenic variants on different chromosomes at the LDLR, Apo-B, PCSK9, or LDLRAP1 genes or greater than or equal to 2 such variants at different loci OR
    B. History of untreated LDL-C greater than 400 mg/dL (greater than 10 mmol/L) AND ONE of the following:
        i. Cutaneous or tendon xanthomas before 10 years of age OR
        ii. Untreated elevated LDL-C levels consistent with heterozygous familial hypercholesterolemia (HeFH) in both parents (or in digenic form, one parent may have normal LDL-C levels and the other may have LDL-C levels consistent with HoFH) AND
3. ONE of the following:
    A. Patient is currently being treated with a 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 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 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, lipidologist) 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 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 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 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. ONE of the following:
            1. Patient has tried and had an inadequate response to immediate-release pregabalin OR
            2. Patient has an intolerance or hypersensitivity to immediate-release pregabalin OR
            3. Patient has an FDA labeled contraindication to immediate-release pregabalin

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 initial approval require ALL of the following:
1. Patient has a diagnosis of facial angiofibroma associated with tuberous sclerosis complex (TSC) AND
2. Patient's diagnosis has been confirmed (i.e., medical records) by ONE of the following:
    A. Patient has a pathogenic variant in the TSC1 gene or TSC2 gene confirmed by genetic testing OR
    B. Patient has TWO of any of the following major features of TSC clinical diagnostic criteria:
        i. hypomelanotic macules (greater than or equal to 3, at least 5 mm diameter)
        ii. angiofibroma (greater than or equal to 3) or fibrous cephalic plaque
        iii. ungual fibromas (greater than or equal to 2)
        iv. shagreen patch
        v. multiple retinal hamartomas
        vi. multiple cortical tubers and/or radial migration lines
        vii. subependymal nodule (greater than or equal to 2)
        viii. subependymal giant cell astrocytoma
        ix. cardiac rhabdomyoma
        x. lymphangiomyomatosis (LAM)*
        xi. angiomyolipomas (greater than or equal to 2)* OR
    C. BOTH of the following:
        i. Patient has ONE of any of the following major features of TSC clinical diagnostic criteria:
            1. hypomelanotic macules (greater than or equal to 3, at least 5 mm diameter)
            2. angiofibroma (greater than or equal to 3) or fibrous cephalic plaque
            3. ungual fibromas (greater than or equal to 2)
            4. shagreen patch
            5. multiple retinal hamartomas
            6. multiple cortical tubers and/or radial migration lines
            7. subependymal nodule (greater than or equal to 2)
            8. subependymal giant cell astrocytoma
            9. cardiac rhabdomyoma
            10. lymphangiomyomatosis (LAM)
            11. angiomyolipomas (greater than or equal to 2) AND

Note:
*A combination of the 2 major clinical features LAM and angiomyolipomas without other features does not meet criteria for a definite diagnosis.

Initial criteria continues: see Other Criteria

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, geneticist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be 12 weeks for initial, 12 months for renewal

Other Criteria:

ii. Patient has TWO of any of the following minor features of TSC clinical diagnostic criteria:

1. "confetti" skin lesions
2. dental enamel pits (greater than or equal to 3)
3. intraoral fibromas (greater than or equal to 2)
4. retinal achromic patch
5. multiple renal cysts
6. nonrenal hamartomas
7. sclerotic bone lesions 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 facial angiofibroma associated with tuberous sclerosis complex (TSC) 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:
Imiquimod PA
Drug Name(s)
Imiquimod Cream 5%
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:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. The requested agent will be used for intermittent treatment of OFF episodes in patients with Parkinson's disease AND
2. The requested agent will be used in combination with carbidopa/levodopa
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)
Firmagon
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Insulin Pen Needle PA
Drug Name(s)
Insulin Pen Needle
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
This program will be implemented as a dynamic PA.
Criteria for approval require BOTH of the following:
1. The requested medical supply product will be used in the delivery of insulin to the body AND
2. Patient's medication history includes use of insulin within the past 180 days
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Insulin Syringe_Needle PA
Drug Name(s)
Insulin Syringe/Needle
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
This program will be implemented as a dynamic PA.
Criteria for approval require BOTH of the following:
1. The requested medical supply product will be used in the delivery of insulin to the body AND
2. Patient's medication history includes use of insulin within the past 180 days
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:
Iqirvo PA
Drug Name(s)
Iqirvo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Have or has developed decompensated cirrhosis (e.g., ascites, variceal bleeding, hepatic encephalopathy)
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 OR
    B. ONE of the following:
        i. Positive presence of antimitochondrial antibody (AMA) OR
        ii. Positive presence of other PBC-specific autoantibodies (e.g., sp100, gp210) if AMA is negative OR
    C. Histologic evidence of nonsuppurative destruction cholangitis and destruction of interlobular bile ducts AND
2. Prescriber has measured the patient's alkaline phosphatase (ALP) level AND total bilirubin level AND
3. ONE of the following:
    A. BOTH of the following:
        i. Patient has tried and had an inadequate response to ursodiol (UDCA) AND
        ii. The requested agent will be used in combination with ursodiol (UDCA) OR
    B. Patient has an intolerance or hypersensitivity to ursodiol (UDCA) OR
    C. Patient has an FDA labeled contraindication to ursodiol (UDCA)

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. The requested agent will be used in combination with ursodiol (UDCA) OR
    B. Patient has an intolerance or hypersensitivity to ursodiol (UDCA) OR
    C. Patient has an FDA labeled contraindication to ursodiol (UDCA) AND
4. 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)
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:
Isotretinoin PA
Drug Name(s)
Absorica
Accutane
Amnesteem
Claravis
Isotretinoin
Zenatane
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. Patient has an FDA labeled indication or 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
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal
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 syndrome AND
2. The requested agent will be used for the treatment of endogenous hypercortisolemia AND
3. ONE of the following:
    A. Patient had an inadequate response to 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. The requested agent will be used for the treatment of endogenous hypercortisolemia 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:
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 the testing laboratory's normal range 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 the testing laboratory's normal range 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 (PI3K) 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 (PI3K) 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:
Jubbonti PA
Drug Name(s)
Jubbonti
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:
Pending CMS Review

Prior Authorization Group Description:
Jynarque PA
Drug Name(s)
Jynarque
Tolvaptan (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:
Leuprolide PA
Drug Name(s)
Eligard
Leuprolide Acetate
Lupron Depot
Lupron Depot-Ped
Lutrate Depot
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. 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
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
L-glutamine PA
Drug Name(s)
Endari
L-glutamine
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 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

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 acute complications of sickle cell disease AND
4. 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:
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)
Lidocaine Patch
Lidocan
Tridacaine Patch
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
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 – ZTlido
Drug Name(s)
Ztlido
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

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:

Liraglutide PA

Drug Name(s)

Liraglutide

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 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 180 days OR
    - B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR
    - C. ALL of the following:
        - i. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        - ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND
        - iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor

Age Restriction:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:Prior Authorization Group Description:
Livdelzi PA
Drug Name(s)
Livdelzi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Have or has developed decompensated cirrhosis (e.g., ascites, variceal bleeding, hepatic encephalopathy)
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 OR
    B. ONE of the following:
        i. Positive presence of antimitochondrial antibody (AMA) OR
        ii. Positive presence of other PBC-specific autoantibodies (e.g., sp100, gp210) if AMA is negative OR
    C. Histologic evidence of nonsuppurative destruction cholangitis and destruction of interlobular bile ducts AND
2. Prescriber has measured the patient's alkaline phosphatase (ALP) level AND total bilirubin level AND
3. ONE of the following:
    A. BOTH of the following:
        i. Patient has tried and had an inadequate response to ursodiol (UDCA) AND
        ii. The requested agent will be used in combination with ursodiol (UDCA) OR
    B. Patient has an intolerance or hypersensitivity to ursodiol (UDCA) OR
    C. Patient has an FDA labeled contraindication to ursodiol (UDCA)

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. The requested agent will be used in combination with ursodiol (UDCA) OR
    B. Patient has an intolerance or hypersensitivity to ursodiol (UDCA) OR
    C. Patient has an FDA labeled contraindication to ursodiol (UDCA) AND
4. 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)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:

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. ONE of the following:
    A. Patient has a diagnosis of progressive familial intrahepatic cholestasis (PFIC) OR
    B. 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
Lumryz Starter Pack
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 narcolepsy with cataplexy OR
    B. BOTH of the following:
        i. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness AND
        ii. ONE of the following:
            a. Patient is between the ages of 7 and less than 18 years OR
            b. BOTH of the following:
                1. Patient is 18 years of age or over AND
                2. 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 OR
    C. Patient has another 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. 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 OR
    C. 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
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.
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 [i.e. corticosteroids (e.g., methylprednisolone, prednisone) AND 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 [i.e. corticosteroids (e.g., methylprednisolone, prednisone) AND 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
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 Hcl Er
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 Hcl
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 Hcl (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)
Metadate Cd
Methylphenidate Hcl Cd
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 Hcl 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 Hcl 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 Hcl Er (La) 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 Patch PA
Drug Name(s)
Daytrana
Methylphenidate Patch
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:
Mifepristone PA
Drug Name(s)
Korlym
Mifepristone
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 had an inadequate response to 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:
Migranal PA
Drug Name(s)
Dihydroergotamine Mesylate Spray
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Miplyffa PA
Drug Name(s)
Miplyffa
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 Niemann-Pick disease Type C (NPC) as confirmed by genetic analysis mutation in the NPC1 or NPC2 genes AND
2. The requested agent will be used for the treatment of neurological manifestations of Niemann-Pick disease type C (NPC) AND
3. The requested agent will be used in combination with miglustat

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 Niemann-Pick disease Type C (NPC) AND
3. The requested agent will be used for the treatment of neurological manifestations of Niemann-Pick disease type C (NPC) AND
4. The requested agent will be used in combination with miglustat 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, geneticist, hepatologist, gastroenterologist, 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:
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 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 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR
    C. ALL of the following:
        i. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND
        iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor
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
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 Hcl
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 – 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:
Pending CMS Review

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 (30 microunits/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:
Nemluvio PA
Drug Name(s)
Nemluvio
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 prurigo nodularis (PN) OR
    B. Patient has a diagnosis of moderate-to-severe atopic dermatitis (AD) AND ALL of the following:
        i. Patient has tried and had an inadequate response to a topical steroid (e.g., triamcinolone) AND
        ii. Patient has tried and had an inadequate response to a topical calcineurin inhibitor (e.g., tacrolimus) AND
        iii. The requested agent will be used in combination with a topical steroid (e.g., triamcinolone) or a topical calcineurin inhibitor (e.g., tacrolimus) AND
2. Patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors)

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 prurigo nodularis (PN) OR
    B. BOTH of the following:
        i. Patient has a diagnosis of moderate-to-severe atopic dermatitis (AD) AND
        ii. ONE of the following:
            a. The requested agent will be used in combination with a topical steroid (e.g., triamcinolone) or a topical calcineurin inhibitor (e.g., tacrolimus) OR
            b. BOTH of the following:
                1. Patient's disease activity has sufficiently improved AND
                2. Combination with a topical steroid (e.g., triamcinolone) or a topical calcineurin inhibitor (e.g., tacrolimus) have been tapered and discontinued 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 immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors)
Age Restriction:
For diagnosis of prurigo nodularis (PN), patient is 18 years of age or over. For diagnosis of moderate-to-severe atopic dermatitis (AD), 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:
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. ONE of the following:
    A. Patient has 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. Pretreatment LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) OR
        iii. Patient has clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, corneal arcus, 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. The requested agent will be used to reduce the risk of myocardial infarction and coronary revascularization AND ONE of the following:
        i. Patient has a diagnosis of established atherosclerotic cardiovascular disease (ASCVD) defined as having ONE of the following:
            a. Acute coronary syndrome
            b. History of myocardial infarction
            c. Stable or unstable angina
            d. Coronary or other arterial revascularization
            e. Stroke
            f. Transient ischemic attack
            g. Peripheral arterial disease, including aortic aneurysm, presumed to be of atherosclerotic origin OR
        ii. Patient has a diagnosis of high risk for a cardiovascular disease (CVD) event but without established CVD OR
    C. Patient has a diagnosis of primary hyperlipidemia, [not associated with HeFH, established cardiovascular disease (CVD), or high risk for CVD event without established CVD] AND
2. ONE of the following:
    A. Patient is on 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:
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 heterozygous familial hypercholesterolemia (HeFH) OR
    B. The requested agent will be used to reduce the risk of myocardial infarction and coronary revascularization AND ONE of the following:
        i. Patient has a diagnosis of established atherosclerotic cardiovascular disease (ASCVD) OR
        ii. Patient has a diagnosis of high risk for a cardiovascular disease (CVD) event but without established CVD OR
    C. Patient has a diagnosis of primary hyperlipidemia, [not associated with HeFH, established cardiovascular disease (CVD), or high risk for CVD event without established CVD] AND
3. ONE of the following:
    A. Patient is on 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. ONE of the following:
    A. Patient has 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. Pretreatment LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) OR
        iii. Patient has clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, corneal arcus, 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. The requested agent will be used to reduce the risk of myocardial infarction and coronary revascularization AND ONE of the following:
        i. Patient has a diagnosis of established atherosclerotic cardiovascular disease (ASCVD) defined as having ONE of the following:
            a. Acute coronary syndrome
            b. History of myocardial infarction
            c. Stable or unstable angina
            d. Coronary or other arterial revascularization
            e. Stroke
            f. Transient ischemic attack
            g. Peripheral arterial disease, including aortic aneurysm, presumed to be of atherosclerotic origin OR
        ii. Patient has a diagnosis of high risk for a cardiovascular disease (CVD) event but without established CVD OR
    C. Patient has a diagnosis of primary hyperlipidemia, [not associated with HeFH, established cardiovascular disease (CVD), or high risk for CVD event without established CVD] AND
2. ONE of the following:
    A. Patient is on 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:
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 heterozygous familial hypercholesterolemia (HeFH) OR
    B. The requested agent will be used to reduce the risk of myocardial infarction and coronary revascularization AND ONE of the following:
        i. Patient has a diagnosis of established atherosclerotic cardiovascular disease (ASCVD) OR
        ii. Patient has a diagnosis of high risk for a cardiovascular disease (CVD) event but without established CVD OR
    C. Patient has a diagnosis of primary hyperlipidemia, [not associated with HeFH, established cardiovascular disease (CVD), or high risk for CVD event without established CVD] AND
3. ONE of the following:
    A. Patient is on 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:
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:
Pending CMS Review

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 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
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., 5HT-1F, ergotamine, acute CGRP) OR
    B. The requested agent is being used for migraine prophylaxis AND BOTH of the following:
        i. Patient has 4 or more migraine headache days per month AND
        ii. 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. 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., 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
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group Description:
Nuzyra IV PA
Drug Name(s)
Nuzyra IV
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. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
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
Coverage Duration:
Approval will be for 14 days
Other Criteria:

Prior Authorization Group Description:
Nuzyra Tablet PA
Drug Name(s)
Nuzyra Tablet
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 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. ONE of the following:
        i. Patient has a diagnosis of community-acquired bacterial pneumonia (CABP) caused by Streptococcus pneumoniae, Staphylococcus aureus (methicillin-susceptible isolates), Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Legionella pneumophila, Mycoplasma pneumoniae, or Chlamydophila pneumoniae AND ONE of the following:
            a. Patient has a documented infection that is resistant to TWO of the following: beta-lactams, macrolides, tetracyclines, OR that is resistant to vancomycin at the site of infection OR
            b. Patient has an intolerance or hypersensitivity to TWO of the following: beta-lactams, macrolides, or tetracyclines OR
            c. Patient has an FDA labeled contraindication to TWO of the following: beta-lactams, macrolides, or tetracyclines OR
            d. Patient has an intolerance or hypersensitivity to vancomycin OR
            e. Patient has an FDA labeled contraindication to vancomycin OR
        ii. Patient has a diagnosis of acute bacterial skin and skin structure infections (ABSSSI) caused by Staphylococcus aureus (methicillin-susceptible and -resistant isolates), Staphylococcus lugdunensis, Streptococcus pyogenes, Streptococcus anginosusgrp (includes S. anginosus, S. intermedius, and S. constellatus), Enterococcus faecalis, Enterobacter cloacae, or Klebsiella pneumoniae AND ONE of the following:
            a. 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

Criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
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
Coverage Duration:
Approval will be for 14 days

Other Criteria:

b. Patient has an intolerance or hypersensitivity to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR
c. Patient has an FDA labeled contraindication to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR
d. Patient has an intolerance or hypersensitivity to vancomycin OR
e. Patient has an FDA labeled contraindication to vancomycin AND

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

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:
Ohtuvayre PA
Drug Name(s)
Ohtuvayre
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Omnipod PA
Drug Name(s)
Omnipod Kit
Omnipod Pods
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 diabetes mellitus AND
2. Patient is on an insulin regimen of 3 or more injections per day AND
3. ONE of the following:
    A. Patient is testing glucose levels 4 or more times per day OR
    B. Patient is using a continuous glucose monitor (CGM)

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 diabetes mellitus AND
3. Patient has had clinical benefit with the requested agent (e.g., stable or improved glycemic control)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Onapgo PA
Drug Name(s)
Onapgo
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 advanced Parkinson's disease AND
2. The requested agent will be used for the treatment of motor fluctuations AND
3. 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)
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:
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 – Vevye
Drug Name(s)
Vevye
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 cancer-related pain 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 completed a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis 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 Patch
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 cancer-related pain 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 completed a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis 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 cancer-related pain 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 completed a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis 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 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 cancer-related pain 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 completed a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis 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 cancer-related pain 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 completed a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis 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 cancer-related pain 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 completed a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis 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 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 cancer-related pain 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 completed a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis 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 cancer-related pain 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 completed a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis 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 cancer-related pain 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 completed a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis 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 (pt) 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. Pt is NOT immunocompromised AND
        iii. ONE of the following:
            a. Pt has tried and failed a topical steroid (e.g., triamcinolone) OR
            b. Pt has an intolerance or hypersensitivity to a topical steroid OR
            c. Pt has an FDA labeled contraindication to a topical steroid AND
        iv. ONE of the following:
            a. Pt has tried and failed a topical calcineurin inhibitor (e.g., tacrolimus) OR
            b. Pt has an intolerance or hypersensitivity to a topical calcineurin inhibitor OR
            c. Pt has an FDA labeled contraindication to a topical calcineurin inhibitor OR
    B. Pt has a diagnosis of nonsegmental vitiligo AND
2. Pt 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. 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 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. Pt is NOT immunocompromised OR
    B. Pt has a diagnosis of nonsegmental vitiligo AND
3. Pt has had clinical benefit with the requested agent AND
4. Pt 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
5. The requested dose is within 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, 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 an intranasal corticosteroid AND one other standard allergy agent (e.g., oral or intranasal antihistamines, oral or intranasal corticosteroids, leukotriene inhibitors. note: two separate intranasal corticosteroids meet this criteria) OR
    B. Patient has an intolerance or hypersensitivity to therapy with an intranasal corticosteroid AND one other standard allergy agent OR
    C. Patient has an FDA labeled contraindication to therapy with an intranasal corticosteroid AND one other standard allergy agent 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:

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 an intranasal corticosteroid AND one other standard allergy agent (e.g., oral or intranasal antihistamines, oral or intranasal corticosteroids, leukotriene inhibitors. note: two separate intranasal corticosteroids meet this criteria) OR
    B. Patient has an intolerance or hypersensitivity to therapy with an intranasal corticosteroid AND one other standard allergy agent OR
    C. Patient has an FDA labeled contraindication to therapy with an intranasal corticosteroid AND one other standard allergy agent 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:

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:
Osenvelt PA
Drug Name(s)
Osenvelt
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

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 the following:
1. ONE of the following:
    A. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            1. Plaque psoriasis OR
            2. Active psoriatic arthritis AND
        ii. ONE of the following:
            1. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
            2. 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
            3. Patient's medication history indicates use of a biologic immunomodulator agent for the same FDA labeled indication OR
            4. Patient has tried and had an inadequate response to at least ONE conventional prerequisite agent for the requested indication OR
            5. Patient has an intolerance or hypersensitivity to at least ONE conventional prerequisite agent for the requested indication OR
            6. Patient has an FDA labeled contraindication to at least ONE conventional prerequisite agent for the requested indication OR
    B. 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 ONE of the following diagnoses:
    A. Plaque psoriasis OR
    B. Active psoriatic arthritis OR
    C. 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:
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, geneticist, nephrologist, urologist) 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 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 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR
    C. ALL of the following:
        i. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND
        iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor
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 initial approval require ALL of the following:
1. Patient has a diagnosis of peanut allergy AND
2. Patient's diagnosis has been confirmed by ONE of the following:
    A. A serum peanut-specific IgE level greater than or equal to 0.35 kUA/L OR
    B. A positive skin-prick test determined by a mean wheal diameter that is at least 3mm larger than the negative control upon skin-prick testing for peanut AND
3. Patient is/was 1-17 years of age at the time of initiating therapy AND
4. Patient has been prescribed epinephrine injection for at home emergency use 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 peanut allergy AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient has been prescribed epinephrine injection for at home emergency use 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, 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:
Pending CMS Review

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. 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. 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., mycophenolate)] 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., Enbrel), 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, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Kesimpta, Plegridy, teriflunomide, Vumerity) OR

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

i. Patient has failed ONE conventional therapy (e.g., desmopressin, von Willebrand factor replacement therapy, corticosteroids, 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 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

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
Posaconazole Dr
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:
Approval will be 1 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., biomarkers in serum assay, microbiologic cultures, radiographic evidence) 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:
Pending CMS Review

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:
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 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 -2.5) OR
f. Pt is at high risk for falls or has a history of injurious falls OR
g. Pt has a high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 20%, hip fracture greater than 3%) 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 lower limit of the testing laboratory's normal range OR
B. Pt has a pretreatment or current calcium level that is below the lower limit 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, 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)

Eltrombopag

Promacta

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 (pt) has a diagnosis of persistent or chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following:
        - i. Pt has tried and had an insufficient response to a corticosteroid or immunoglobulin (IVIg or anti-D) OR
        - ii. Pt has an intolerance or hypersensitivity to a corticosteroid or immunoglobulin (IVIg or anti-D) OR
        - iii. Pt has an FDA labeled contraindication to a corticosteroid or immunoglobulin (IVIg or anti-D) OR
        - iv. Pt has had an insufficient response to a splenectomy OR
    - B. Pt has a diagnosis of hepatitis C associated thrombocytopenia AND ONE of the following:
        - i. Pt's platelet count is less than 75 x 10^9/L AND the intent is to increase platelet counts sufficiently to initiate interferon therapy OR
        - ii. Pt is on concomitant therapy with interferon therapy AND is at risk for discontinuing hepatitis C therapy due to thrombocytopenia OR
    - C. Pt has a diagnosis of severe aplastic anemia (SAA) AND ALL of the following:
        - i. Pt has at least 2 of the following blood criteria:
            1. Neutrophils less than 0.5 X 10^9/L OR
            2. Platelets less than 30 X 10^9/L OR
            3. Reticulocyte count less than 60 X 10^9/L AND
        - ii. Pt has at least 1 of the following marrow criteria:
            1. Severe hypocellularity is less than 25% OR
            2. Moderate hypocellularity is 25-50% with hematopoietic cells representing less than 30% of residual cells AND
        - iii. ONE of the following:
            1. Pt has tried and had an insufficient response to BOTH antithymocyte globulin (ATG) AND cyclosporine therapy OR
            2. BOTH of the following:
                - a. Pt will be using the requested agent as first-line treatment (i.e., has not been treated with ATG and/or cyclosporine) AND
                - b. Pt will use the requested agent in combination with standard immunosuppressive therapy (i.e., ATG AND cyclosporine) OR

Initial criteria continues: see Other Criteria

Age Restriction:

Prescriber Restrictions:
Coverage Duration:
Initial: 6 months for ITP. Renewal: 12 months for ITP. Other indications, see Other Criteria.
Other Criteria:

D. Pt 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. 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 interferon therapy OR

2. Pt will be maintaining hepatitis C therapy with interferon therapy 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 interferon 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 AND

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

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 2 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 2 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 BOTH of the following:

1. Patient has unacceptable or deteriorating clinical status despite established 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

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 2 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 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 OR

e. The requested agent will be utilized as part of triple therapy in a treatment naive patient AND BOTH of the following:

1. Patient is classified as WHO functional class IV or has been assessed as high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND
2. The three agents being utilized consist of: ERA plus PDE5i plus prostanoid

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 2 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 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 OR

e. The requested agent will be utilized as part of triple therapy in a treatment naive patient AND BOTH of the following:

1. Patient is classified as WHO functional class IV or has been assessed as high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND
2. The three agents being utilized consist of: ERA plus PDE5i plus prostanoid 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 2 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 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 OR

e. The requested agent will be utilized as part of triple therapy in a treatment naive patient AND BOTH of the following:

1. Patient is classified as WHO functional class IV or has been assessed as high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND
2. The three agents being utilized consist of: ERA plus PDE5i plus prostanoid

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 – Opsynvi
Drug Name(s)
Opsynvi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Concurrently taking another phosphodiesterase 5 (PDE5) 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 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 2 Wood units AND
        v. ONE of the following:
            a. The requested agent will be utilized as dual therapy OR
            b. The requested agent will be utilized for add-on therapy to existing monotherapy (triple 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

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 – Orenitram
Drug Name(s)
Orenitram
Orenitram 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 2 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 or has been assessed as intermediate to high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) 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:

d. The requested agent will be utilized as part of triple therapy in a treatment naive patient AND BOTH of the following:

1. Patient is classified as WHO functional class IV or has been assessed as high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND
2. The three agents being utilized consist of: ERA plus PDE5i plus prostanoid OR

e. The requested agent will be utilized for add-on therapy to existing triple therapy (quadruple therapy), AND ALL of the following:

1. Patient is WHO functional class III or IV or has been assessed as intermediate to high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND
2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
3. All four agents in the quadruple 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 – Sildenafil
Drug Name(s)
Revatio
Sildenafil Citrate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Concurrently taking another phosphodiesterase 5 (PDE5) 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 2 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 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 OR

e. The requested agent will be utilized as part of triple therapy in a treatment naive patient AND BOTH of the following:

1. Patient is classified as WHO functional class IV or has been assessed as high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND

2. The three agents being utilized consist of: ERA plus PDE5i plus prostanoid 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 Tablet 20Mg
Tadliq
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Concurrently taking another phosphodiesterase 5 (PDE5) 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 2 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 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 OR

e. The requested agent will be utilized as part of triple therapy in a treatment naive patient AND BOTH of the following:

1. Patient is classified as WHO functional class IV or has been assessed as high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND

2. The three agents being utilized consist of: ERA plus PDE5i plus prostanoid 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
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

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 2 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 OR
d. The requested agent will be utilized for add-on therapy to existing triple therapy (quadruple therapy), AND BOTH of the following:

1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
2. All four agents in the quadruple 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 – 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 2 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 or has been assessed as intermediate to high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) 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:

d. The requested agent will be utilized as part of triple therapy in a treatment naive patient AND BOTH of the following:

1. Patient is classified as WHO functional class IV or has been assessed as high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND
2. The three agents being utilized consist of: ERA plus PDE5i plus prostanoid OR

e. The requested agent will be utilized for add-on therapy to existing triple therapy (quadruple therapy), AND ALL of the following:

1. Patient is WHO functional class III or IV or has been assessed as intermediate to high risk using another PAH risk stratification tool (e.g., 6-minute walking distance, natriuretic peptide) AND
2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
3. All four agents in the quadruple 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

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

Prior Authorization Group Description:
Pulmonary Hypertension PA – Winrevair
Drug Name(s)
Winrevair
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 2 Wood units AND
        v. ALL of the following:
            a. The requested agent will be utilized for add-on therapy AND
            b. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
            c. All agents in the 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 – Yutrepia
Drug Name(s)
Yutrepia
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Pyrimethamine PA
Drug Name(s)
Daraprim
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) AND ALL of the following:
    A. ONE of the following:
        i. Genetic testing showing a pathogenic PKLR gene mutation OR
        ii. Patient does NOT have two known pathogenic mutations in the PKLR gene, AND patient has a decrease in pyruvate kinase enzyme activity AND
    B. Patient is NOT homozygous for the c.1436G to A (p.R479H) variant AND
    C. Patient has at least 2 variant alleles in the PKLR gene, of which at least 1 is a missense variant AND
    D. Patient does NOT have two non-missense 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 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)
Quinine Sulfate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

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 or more headache days per month AND
4. 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:
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. ALL of the following:
i. ONE of the following:
a. Patient has a diagnosis of anemia associated with myelodysplastic syndrome with ring sideroblasts (MDS-RS) OR
b. Patient has a diagnosis of anemia associated with myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDC/MPN-RS-T) AND
ii. Patient has very low- to intermediate-risk disease AND
iii. ONE of the following:
a. BOTH of the following:
i. Patient does NOT have a del(5q) abnormality AND
ii. ONE of the following:
1. Patient has ring sideroblasts (RS) greater than or equal to 15% OR
2. Patient has RS greater than or equal to 5% AND an SF3B1 mutation OR
b. BOTH of the following:
i. 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
ii. 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 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:
Pending CMS Review

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 Hcl 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 Injection
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 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 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:
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. ONE of the following:
            a. Patient is 18 years of age or older AND has a pretreatment LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) OR
            b. Patient is between the ages of 10 and less than 18 years of age AND has a pretreatment LDL-C greater than 155 mg/dL (greater than 4.0 mmol/L) OR
        iii. Clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, corneal arcus, tuberous xanthoma, or xanthelasma) OR
        iv. “Definite” or “possible” familial hypercholesterolemia as defined by the Simon Broome criteria OR
        v. A Dutch Lipid Clinic Network criteria score of greater than 5 OR
        vi. A treated low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 100 mg/dL 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 bi-allelic pathogenic/likely pathogenic variants on different chromosomes at the LDLR, Apo-B, PCSK9, or LDLRAP1 genes or greater than or equal to 2 such variants at different loci OR
        ii. History of untreated LDL-C greater than 400 mg/dL (greater than 10 mmol/L) AND ONE of the following:
            a. Cutaneous or tendon xanthomas before 10 years of age OR
            b. Untreated elevated LDL-C levels consistent with heterozygous familial hypercholesterolemia (HeFH) in both parents (or in digenic form, one parent may have normal LDL-C levels and the other may have LDL-C levels consistent with HoFH) OR

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

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

C. BOTH of the following:

i. A diagnosis of established cardiovascular disease [acute coronary syndrome (ACS), history of myocardial infarction (MI), stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack (TIA), peripheral artery disease (PAD) including aortic aneurysm] AND

ii. The requested agent will be used to reduce the risk of major adverse cardiovascular (CV) events (CV death, myocardial infarction, stroke, unstable angina requiring hospitalization, or coronary revascularization) OR

D. A diagnosis of primary hyperlipidemia (not associated with HeFH, HoFH, or established cardiovascular disease) OR

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

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:
Revcovi PA
Drug Name(s)
Revcovi
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 adenosine deaminase severe combined immune deficiency (ADA-SCID) confirmed by ONE of the following:
    A. Molecular genetic confirmation of mutations in both alleles of the ADA1 gene OR
    B. Deficiency or absence of ADA in lysed erythrocytes, fibroblasts (cultured from amniotic fluid), or chorionic villus OR
    C. Positive screening by T cell receptor excision circles (TRECs) OR
    D. Increase in deoxyadenosine triphosphate (dATP) levels in erythrocyte lysates over the testing laboratory's upper limit of the normal range 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 adenosine deaminase severe combined immune deficiency (ADA-SCID) 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., geneticist, hematologist, immunologist, oncologist) 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:
Reyvow PA
Drug Name(s)
Reyvow
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Rezdiffra PA
Drug Name(s)
Rezdiffra
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Decompensated cirrhosis AND Moderate to severe hepatic impairment (Child-Pugh Class B or C)
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis AND
2. Patient has stage F2 or F3 fibrosis as confirmed by BOTH of the following (prior to therapy with the requested agent):
    A. A FIB-4 score consistent with stage F2 or F3 fibrosis adjusted for age AND
    B. ONE of the following:
        i. A liver biopsy OR
        ii. ONE of the following:
            1. Vibration-controlled transient elastography (VCTE, e.g., Fibroscan) OR
            2. Enhanced liver fibrosis (ELF) OR
            3. Magnetic resonance elastography (MRE)

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 noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis 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., hepatologist, 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:
Rezurock PA
Drug Name(s)
Rezurock
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 graft-versus-host disease (chronic GVHD) AND
2. Patient has failed at least two prior lines of 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 chronic graft-versus-host disease (chronic GVHD) 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., hematologist, oncologist) 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:
Ritalin LA PA
Drug Name(s)
Methylphenidate Hcl 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 Hcl (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:
Rivfloza PA
Drug Name(s)
Rivfloza
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 oxalate levels AND
3. Patient has an estimated GFR (eGFR) greater than or equal to 30 mL/min/1.73^2 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 primary hyperoxaluria type 1 (PH1) AND
3. The requested agent will be used to lower urinary oxalate levels AND
4. Patient has an estimated GFR (eGFR) greater than or equal to 30 mL/min/1.73^2 AND
5. Patient has had clinical benefit with the requested agent AND
6. 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, geneticist, nephrologist, urologist) 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:
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:
Pending CMS Review

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 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 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR
    C. ALL of the following:
        i. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND
        iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor
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 (Samsca)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Any underlying liver disease, including cirrhosis AND FDA labeled contraindications to the requested agent
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
Abirtega
Afinitor
Afinitor Disperz
Akeega
Alecensa
Alunbrig
Augtyro
Avmapki Fakzynja Co-Pack
Ayvakit
Balversa
Besremi
Bexarotene Capsules
Bosulif
Braftovi
Brukinsa
Cabometyx
Calquence
Caprelsa
Cometriq
Copiktra
Cotellic
Danziten
Dasatinib
Daurismo
Erivedge
Erleada
Erlotinib Hcl
Everolimus
Fotivda
Fruzaqla
Gavreto
Gefitinib
Gilotrif
Gleevec
Gomekli
Hernexeos
Ibrance
Ibtrozi
Iclusig
Idhifa

Imatinib Mesylate
Imbruvica
Imkeldi
Inlyta
Inqovi
Inrebic
Iressa
Itovebi
Iwilfin
Jakafi
Jaypirca
Kisqali
Kisqali Femara
Koselugo
Krazati
Lapatinib Ditosylate
Lazcluze
Lenalidomide
Lenvima
Lonsurf
Lorbrena
Lumakras
Lynparza
Lytgobi
Matulane
Mekinist
Mektovi
Modeyso
Nerlynx
Nexavar
Nilotinib
Ninlaro
Nubeqa
Odomzo
Ogsiveo
Ojemda
Ojjaara
Onureg
Orgovyx
Orserdu
Pazopanib Hcl
Pemazyre
Piqray
Pomalyst

Qinlock
Retevmo
Revlimid
Revuforj
Rezlidhia
Romvimza
Rozlytrek
Rubraca
Rydapt
Scemblix
Sorafenib
Sprycel
Stivarga
Sunitinib Malate
Sutent
Tabrecta
Tafinlar
Tagrisso
Talzenna
Targretin Capsule
Tasigna
Tazverik
Tepmetko
Thalomid
Tibsovo
Torpenz
Tretinoin Capsule
Truqap
Tukysa
Turalio
Tykerb
Vanflyta
Venclexta
Venclexta Starting Pack
Verzenio
Vitrakvi
Vizimpro
Vonjo
Voranigo
Votrient
Welireg
Xalkori
Xospata
Xpovio

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 CMS approved compendia as a 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
        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
    b. The requested agent is Bosulif AND ONE of the following:
        1. Patient's medication history indicates use of imatinib OR dasatinib for the requested indication (if applicable) OR
        2. Patient has an intolerance or hypersensitivity to imatinib OR dasatinib OR
        3. Patient has an FDA labeled contraindication to imatinib OR dasatinib OR
        4. CMS approved compendia does not support the use of imatinib OR dasatinib for the requested indication OR
        5. Prescriber has provided information in support of use of Bosulif over imatinib OR dasatinib for the requested indication AND
vi. ONE of the following:
    a. The requested agent is not Ibrance OR
    b. The requested agent is Ibrance AND ONE of the following:
        1. Patient's medication history indicates use of Kisqali, Kisqali/Femara, OR Verzenio for the requested indication (if applicable) OR
        2. Patient has an intolerance or hypersensitivity to Kisqali, Kisqali/Femara, OR Verzenio OR
        3. Patient has an FDA labeled contraindication to Kisqali, Kisqali/Femara, OR Verzenio OR
        4. CMS approved compendia does not support the use of Kisqali, Kisqali/Femara, OR Verzenio for the requested indication OR
        5. Prescriber has provided information in support of use of Ibrance over Kisqali, Kisqali/Femara, OR Verzenio for the requested indication AND
vii. ONE of the following:
    a. The requested agent is not Ojjaara OR Inrebic OR
    b. The requested agent is Ojjaara OR Inrebic AND ONE of the following:
        1. Patient's medication history indicates use of Jakafi for the requested indication (if applicable) OR
        2. Patient has an intolerance or hypersensitivity to Jakafi OR
        3. Patient has an FDA labeled contraindication to Jakafi OR
        4. CMS approved compendia does not support the use of Jakafi for the requested indication OR
        5. Prescriber has provided information in support of use of Ojjaara OR Inrebic over Jakafi 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:
Pending CMS Review

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:
Skyclarys PA
Drug Name(s)
Skyclarys
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 initial approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of narcolepsy with cataplexy OR
    B. BOTH of the following:
        i. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness AND
        ii. ONE of the following:
            a. Patient is between the ages of 7 and less than 18 years OR
            b. BOTH of the following:
                1. Patient is 18 years of age or over AND
                2. 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 OR
    C. Patient has another 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. 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 OR
    C. 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
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.
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)
Octreotide Kit
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 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 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:
Pending CMS Review

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 the preferred agent: Mavyret 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 the preferred agent: Mavyret 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:
Spevigo SC PA
Drug Name(s)
Spevigo
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 generalized pustular psoriasis (GPP) AND
2. The requested agent will be used for treatment of GPP when NOT experiencing a flare AND
3. Patient does NOT have active tuberculosis (TB) AND
4. ONE of the following:
    A. Patient does NOT have latent tuberculosis (TB) OR
    B. Patient has latent tuberculosis (TB) and the patient has begun or completed therapy for latent TB prior to initiating 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:
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:
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:
Stoboclo PA
Drug Name(s)
Stoboclo
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:
Pending CMS Review

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 (prior to therapy for the requested indication) 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 the glucocerebrosidase (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. 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 clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, geneticist, hematologist, hepatologist, 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, Some Medically-Accepted Indications.
Off-Label Uses:
Niemann-Pick disease type C (NPC)
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 Gaucher disease type 1 (GD1) confirmed by ONE of the following:
            a. A baseline (prior to therapy for the requested indication) 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 the glucocerebrosidase (GBA) gene with two disease-causing alleles AND
        ii. 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 OR
    B. ALL of the following:
        i. Patient has a diagnosis of Niemann-Pick disease type C (NPC) as confirmed by genetic analysis mutation in the NPC1 or NPC2 genes AND
        ii. The requested agent will be used for the treatment of neurological manifestations of Niemann-Pick disease type C (NPC) AND
        iii. The requested agent will be used in combination with Miplyffa (arimoclomol)
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, gastroenterologist, geneticist, hematologist, hepatologist, neurologist, 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:

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 Gaucher disease type 1 (GD1) OR
    B. ALL of the following:
        i. Patient has a diagnosis of Niemann-Pick disease type C (NPC) AND
        ii. The requested agent will be used for the treatment of neurological manifestations of Niemann-Pick disease type C (NPC) AND
        iii. The requested agent will be used in combination with Miplyffa (arimoclomol) AND
3. Patient has had clinical benefit with the requested agent

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, geneticist, 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:
FDA labeled contraindications to the requested agent
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 OR
    B. Patient has a diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea (OSA) AND
2. 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
3. Patient will NOT be using the requested agent in combination with modafinil or armodafinil 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 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 or armodafinil for the requested indication AND
4. 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:
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 the loss of kidney function AND
3. Patient is at risk of disease progression as shown by ONE of the following:
    A. A urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.44 g/g OR
    B. Proteinuria greater than or equal to 0.5 g/day AND
4. ONE of the following:
    A. Patient has tried and had an inadequate response with a maximally tolerated angiotensin-converting-enzyme inhibitor (ACEI) [e.g., benazepril, lisinopril], or angiotensin II blocker (ARB) [e.g., losartan], or a combination medication containing an ACEI or ARB OR
    B. Patient has an intolerance or hypersensitivity to an ACEI or ARB, or a combination medication containing an ACEI or ARB OR
    C. Patient has an FDA labeled contraindication to an ACEI or ARB, or a combination medication containing an ACEI 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 ALL 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 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 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 AND
3. 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:
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:
Teriparatide PA
Drug Name(s)
Bonsity
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:
    A. Postmenopausal 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 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 -2.5) OR
        vi. Patient is at high risk for falls or has a history of injurious falls OR
        vii. Patient has a high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 20%, hip fracture greater than 3%) 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, or a combination of teriparatide and Tymlos (abaloparatide), 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 or a combination of teriparatide and Tymlos (abaloparatide)

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:
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 the testing laboratory's normal range 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 the testing laboratory's normal range 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) OR
    b. Patient is currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam) 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) OR
    b. Patient is currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam) 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 Gel 3%
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 Hcl
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:
Approval will be 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:
Approval will be 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
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 Hcl
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:
Pending CMS Review

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 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 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR
    C. ALL of the following:
        i. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND
        iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Tryngolza PA
Drug Name(s)
Tryngolza
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 familial chylomicronemia syndrome (FCS) confirmed by ONE of the following:
    A. Genetic confirmation of bi-allelic pathogenic variants in affected genes (e.g., LPL, ApoA5, ApoC2, LMF1, GPIHBP1, or G3PDH1) OR
    B. ALL of the following:
        i. Fasting triglyceride (TG) levels greater than 880 mg/dL (10 mmol/L) for 3 consecutive measurements AND
        ii. Secondary causes of hypertriglyceridemia have been ruled out (e.g., alcohol use, chronic kidney disease, hypothyroidism, uncontrolled diabetes, medications [e.g., atypical antipsychotics, beta-blockers, corticosteroids, oral estrogens]) AND
        iii. History of pancreatitis or unexplained recurrent abdominal pain

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 familial chylomicronemia syndrome (FCS) 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., cardiologist, endocrinologist, geneticist, lipidologist) 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:
Tryvio PA
Drug Name(s)
Tryvio
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 hypertension AND
2. Patient is still not at blood pressure goal while on TWO other different antihypertensive therapy classes [e.g., angiotensin converting enzyme inhibitor (ACEI) (e.g., lisinopril), angiotensin receptor blocker (ARB) (e.g., losartan), beta blocker (e.g., atenolol), calcium channel blocker (e.g., amlodipine), diuretic (e.g., hydrochlorothiazide), mineralocorticoid receptor antagonist (e.g., spironolactone)] AND
3. The requested agent will be used in combination with other antihypertensive therapies [e.g., angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), beta blocker]

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 hypertension AND
3. The requested agent will be used in combination with other antihypertensive therapies [e.g., angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), beta blocker] 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:

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 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., 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., 5HT-1F, ergotamine, acute CGRP)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Undecatrex PA
Drug Name(s)
Undecatrex
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 the testing laboratory's normal range 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 the testing laboratory's normal range 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:
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 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 – 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 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 – 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:
Valchlor PA
Drug Name(s)
Valchlor
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. BOTH of the following:
        i. ONE of the following:
            a. BOTH of the following:
                1. Patient has a diagnosis of Stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma AND
                2. Patient's medication history indicates use of at least ONE prior skin-directed therapy (e.g., topical corticosteroid) OR
            b. 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

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. 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
Age Restriction:

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

Prior Authorization Group Description:
Vanrafia PA
Drug Name(s)
Vanrafia
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

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:
V-Go PA
Drug Name(s)
V-Go
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 diabetes mellitus AND
2. Patient is on an insulin regimen of 3 or more injections per day AND
3. ONE of the following:
    A. Patient is testing glucose levels 4 or more times per day OR
    B. Patient is using a continuous glucose monitor (CGM)

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 diabetes mellitus AND
3. Patient has had clinical benefit with the requested agent (e.g., stable or improved glycemic control)
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:
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 (VVC) 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. BOTH of the following:
        i. ONE of the following:
            1. Patient has a diagnosis of esophageal candidiasis OR
            2. Patient has a diagnosis of candidemia in nonneutropenic patient OR
            3. Patient has a diagnosis of other deep tissue Candida infections AND
        ii. ONE of the following:
            1. Patient has tried and had an inadequate response to fluconazole or an alternative antifungal agent OR
            2. Patient has an intolerance or hypersensitivity to fluconazole or an alternative antifungal agent OR
            3. 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:
Approval will be 1 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, other deep tissue Candida infections, or blastomycosis and patient has continued indicators of active disease (e.g., biomarkers in serum assay, microbiologic cultures, radiographic evidence) 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:
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:
Voydeya PA
Drug Name(s)
Voydeya
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 paroxysmal nocturnal hemoglobinuria (PNH) AND
2. The requested agent will be used for the treatment of extravascular hemolysis (EVH) AND
3. The requested agent will be used in combination with Soliris (eculizumab) or Ultomiris (ravulizumab-cwvz)

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 paroxysmal nocturnal hemoglobinuria (PNH) AND
3. The requested agent will be used for the treatment of extravascular hemolysis (EVH) AND
4. The requested agent will be used in combination with Soliris (eculizumab) or Ultomiris (ravulizumab-cwvz) AND
5. Patient has had clinical benefit with the requested agent [e.g., decreased requirement for packed red blood cell transfusions, stabilization/improvement of hemoglobin]
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:
Vtama PA
Drug Name(s)
Vtama
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 plaque psoriasis AND BOTH of the following:
        i. 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 corticosteroid OR
            c. Patient has an FDA labeled contraindication to a topical corticosteroid AND
        ii. 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 OR
    B. Patient has a diagnosis of atopic dermatitis AND BOTH of the following:
        i. 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 corticosteroid OR
            c. Patient has an FDA labeled contraindication to a topical corticosteroid AND
        ii. ONE of the following:
            a. Patient has tried and failed a topical calcineurin inhibitor (e.g., 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

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 plaque psoriasis OR
    B. Patient has a diagnosis of atopic dermatitis 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:
Vykat XR PA
Drug Name(s)
Vykat XR
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

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 diagnosis has been confirmed by testing [e.g., stannous pyrophosphate (PYP) scanning, monoclonal antibody studies, biopsy, scintigraphy, genetic testing (TTR genotyping)] AND
3. The requested agent will be used to reduce cardiovascular mortality and cardiovascular-related hospitalization AND
4. Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure AND
5. Patient has clinical manifestations of cardiomyopathy (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema) AND
6. Patient will NOT be using the requested agent in combination with another tafamidis agent, Amvuttra, or Attruby 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 New York Heart Association (NYHA) Functional Class I, II, or III heart failure AND
5. Patient has had clinical benefit with the requested agent AND
6. Patient will NOT be using the requested agent in combination with another tafamidis agent, Amvuttra, or Attruby 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 diagnosis has been confirmed by testing [e.g., stannous pyrophosphate (PYP) scanning, monoclonal antibody studies, biopsy, scintigraphy, genetic testing (TTR genotyping)] AND
3. The requested agent will be used to reduce cardiovascular mortality and cardiovascular-related hospitalization AND
4. Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure AND
5. Patient has clinical manifestations of cardiomyopathy (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema) AND
6. Patient will NOT be using the requested agent in combination with another tafamidis agent, Amvuttra, or Attruby 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 New York Heart Association (NYHA) Functional Class I, II, or III heart failure AND
5. Patient has had clinical benefit with the requested agent AND
6. Patient will NOT be using the requested agent in combination with another tafamidis agent, Amvuttra, or Attruby 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:
Vyvgart Hytrulo PA
Drug Name(s)
Vyvgart Hytrulo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Wainua PA
Drug Name(s)
Wainua
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 polyneuropathy of hereditary transthyretin-mediated amyloidosis AND
2. The diagnosis has been confirmed by biopsy or genetic testing AND
3. Patient has clinical manifestations of polyneuropathy (e.g., neuropathic pain, altered sensation, numbness, tingling, impaired balance, motor disability) AND
4. Patient will NOT be using the requested agent in combination with Amvuttra (vutrisiran), Onpattro (patisiran), or Tegsedi (inotersen) for the requested indication 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 polyneuropathy of hereditary transthyretin-mediated amyloidosis AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with Amvuttra (vutrisiran), Onpattro (patisiran), or Tegsedi (inotersen) 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., 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:
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. BOTH of the following:
        i. Patient has a diagnosis of excessive daytime sleepiness associated with narcolepsy AND
        ii. ONE of the following:
            a. Patient is between the ages of 6 and less than 18 years OR
            b. BOTH of the following:
                1. Patient is 18 years of age or over AND
                2. 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

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:
For diagnosis of narcolepsy with cataplexy, patient is 18 years of age or over. For diagnosis of excessive daytime sleepiness associated with narcolepsy, patient is 6 years of age or over.
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Wegovy PA
Drug Name(s)
Wegovy
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone AND FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

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:
Wyost PA
Drug Name(s)
Wyost
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Xdemvy PA
Drug Name(s)
Xdemvy
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has a diagnosis of Demodex blepharitis AND BOTH of the following:
    A. Patient has ONE of the following signs of Demodex infestation:
        i. Collarettes (cylindrical dandruff at the eyelash base) OR
        ii. Lid margin erythema or edema OR
        iii. Conjunctival injection OR
        iv. Eyelash misdirection/irregularity AND
    B. Patient has ONE of the following symptoms of Demodex infestation:
        i. Blurred/fluctuating vision OR
        ii. Discharge or crusting on lashes OR
        iii. Dryness OR
        iv. Foreign body sensation OR
        v. Itching OR
        vi. Pain/burning OR
        vii. Watering/tearing
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., infectious disease, ophthalmologist, optometrist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
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, dimethyl fumarate, fingolimod, glatiramer, Glatopa, Kesimpta, 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., octreotide) AND
3. The requested agent will be used in combination with a somatostatin analog (e.g., octreotide)

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., octreotide)
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 another form of denosumab AND
3. The requested dose is within FDA labeled dosing for the requested indication

Prior Authorization Group Description:
Xifaxan 200 MG Tablet PA
Drug Name(s)
Xifaxan 200Mg
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 traveler's diarrhea (TD) AND
2. Patient's traveler's diarrhea is caused by noninvasive strains of Escherichia coli
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:
Xifaxan 550 MG Tablet PA
Drug Name(s)
Xifaxan 550Mg
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]
Age Restriction:
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:
                1. Patient's pretreatment IgE level is 30 IU/mL to 1300 IU/mL AND
                2. Patient's weight is 20 kg to 150 kg OR
            b. Patient is 12 years of age or over AND BOTH of the following:
                1. Patient's pretreatment IgE level is 30 IU/mL to 700 IU/mL AND
                2. Patient's weight is 30 kg to 150 kg AND
        ii. Allergic asthma has been confirmed by a positive skin test or in vitro reactivity test to a perennial aeroallergen AND
        iii. ONE of the following:
            a. 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 an intolerance, FDA labeled contraindication, or hypersensitivity to an asthma control therapy OR
    B. Patient has a diagnosis of chronic idiopathic urticaria (CSU) 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 chronic rhinosinusitis with nasal polyps (CRSwNP) 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 OR

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 (CSU), patient is 12 years of age or over. For diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP), patient is 18 years of age or over. For diagnosis of IgE-mediated food allergy, patient is 1 year of age or over.

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, hematologist, immunologist, oncologist, 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:

D. Patient has a diagnosis of IgE-mediated food allergy AND ALL of the following:

i. Patient is using the requested agent for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods AND

ii. IgE-mediated food allergy has been confirmed by an allergy diagnostic test (e.g., skin prick test, serum specific IgE test, oral food challenge) AND

iii. Patient will avoid known food allergens while treated with the requested agent AND

iv. The requested agent will NOT be used for the emergency treatment of allergic reactions, including anaphylaxis AND

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 BOTH of the following:

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

ii. ONE of the following:

a. 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 an intolerance, FDA labeled contraindication, or hypersensitivity to an asthma control therapy OR

B. Patient has a diagnosis of chronic idiopathic urticaria (CSU) AND the following:

a. Patient has had clinical benefit with the requested agent OR

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

a. Patient has had clinical benefit with the requested agent OR

D. Patient has a diagnosis of IgE-mediated food allergy AND ALL of the following:

a. Patient is using the requested agent for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods AND

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

c. Patient will avoid known food allergens while treated with the requested agent AND

d. The requested agent will NOT be used for the emergency treatment of allergic reactions, including anaphylaxis 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:
Xolremdi PA
Drug Name(s)
Xolremdi
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 WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome AND
2. BOTH of the following:
    a. Patient has a genetic analysis confirming mutation in the CXC chemokine receptor 4 (CXCR4) gene AND
    b. Patient has a confirmed absolute neutrophil count (ANC) OR total white blood cell (WBC) less than or equal to 400 cells/microliter (prior to therapy with the requested agent AND during no clinical evidence of infection) AND
3. The requested agent will be used to increase the number of circulating mature neutrophils and lymphocytes

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 WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome AND
3. The requested agent will be used to increase the number of circulating mature neutrophils and lymphocytes AND
4. 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, geneticist, hematologist, 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:
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 initial approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of narcolepsy with cataplexy OR
    B. BOTH of the following:
        i. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness AND
        ii. ONE of the following:
            a. Patient is between the ages of 7 and less than 18 years OR
            b. BOTH of the following:
                1. Patient is 18 years of age or over AND
                2. 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 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

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 narcolepsy with excessive daytime sleepiness 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 AND
3. Patient has had clinical benefit with 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:
Yorvipath PA
Drug Name(s)
Yorvipath
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 hypoparathyroidism AND
2. Patient does NOT have acute post-surgical hypoparathyroidism AND
3. Patient does NOT have a baseline (prior to therapy with the requested agent) vitamin D level below the testing laboratory's lower limit of normal AND
4. Patient has baseline (prior to therapy with the requested agent) albumin-corrected serum calcium of at least 7.8 mg/dL

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 hypoparathyroidism AND
3. Patient does NOT have acute post-surgical hypoparathyroidism 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., 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:
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., 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., 5HT-1F, ergotamine, acute CGRP)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Prior Authorization Group Description:
Zelsuvmi PA
Drug Name(s)
Zelsuvmi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

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 the preferred agent: Mavyret 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 the preferred agent: Mavyret 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:
Zepbound PA
Drug Name(s)
Zepbound
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone AND FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Zilbrysq PA
Drug Name(s)
Zilbrysq
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 ALL of the following:
    A. Diagnosis of generalized myasthenia gravis (gMG) AND
    B. A positive serological test for anti-AChR antibodies AND
    C. A Myasthenia Gravis Foundation of America (MGFA) clinical classification class of II-IV prior to treatment with the requested agent AND
    D. A Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score of greater than or equal to 6 prior to treatment 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 generalized myasthenia gravis (gMG) AND
3. Patient has had clinical benefit with the requested agent [e.g., stabilization/improvement of Myasthenia Gravis-Activities of Daily Living score (MG-ADL) or Quantitative MG score (QMG)]
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:
Zoryve 0.15% Cream PA
Drug Name(s)
Zoryve Cream 0.15%
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 mild to moderate 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

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 mild to moderate atopic dermatitis 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:
Zoryve 0.3% Cream PA
Drug Name(s)
Zoryve Cream 0.3%
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 corticosteroid OR
    C. Patient has an FDA labeled contraindication to a topical corticosteroid 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:
Zoryve Foam PA
Drug Name(s)
Zoryve Foam
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Ztalmy PA
Drug Name(s)
Ztalmy
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 seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) 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's diagnosis has been confirmed with genetic testing indicating variant in CDKL5 gene 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

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 seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) 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. 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
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:
Zyclara PA
Drug Name(s)
Imiquimod Cream 3.75% (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: