



# CarePartners of Connecticut 2025 Prior Authorization Medical Necessity Guidelines

Effective: November 1, 2025

# ABILIFY MYCITE

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## Products Affected

- Abilify Mycite Maintenance Kit  
TBPK 10MG
- Abilify Mycite Starter Kit TBPK  
15MG, 20MG, 2MG, 30MG, 5MG

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must meet the following: 1) have a documented diagnosis of bipolar I disorder, major depressive disorder or schizophrenia 2) the member must have documentation of worsening symptoms with oral aripiprazole. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a psychiatrist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# ABIRATERONE

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## Products Affected

- Abiraterone Acetate

- Abirtega

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of metastatic castration-resistant prostate cancer (CRPC) or metastatic high-risk castration-sensitive prostate cancer and abiraterone is being used in combination with prednisone. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist or urologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# AIMOVIG

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## Products Affected

- Aimovig

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Initial: The member must have a documented diagnosis of migraine and the member has had an inadequate response after a 4-week trial of or has a contraindication to antidepressants, antiepileptic drugs (AEDs) or beta blockers. Subsequent: The member has had a clinically significant reduction in migraine days per month from baseline. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | Initial Approval: 6 months. Subsequent approval: 2 years  |
| <b>Other Criteria</b>               | N/A   |

# AKEEGA

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## Products Affected

- Akeega

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | 1) Diagnosis of prostate cancer and disease is all of the following: a) metastatic, b) castration-resistant, and c) deleterious or suspected deleterious BRCA-mutated (BRCAm) and 2) Requested drug is being used in combination with prednisone and 3) One of the following: a) Used in combination with a gonadotropin-releasing hormone (GnRH) analog, or b) Patient has had a bilateral orchiectomy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescriber must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# ALECENSA

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## Products Affected

- Alecensa

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of Anaplastic Lymphoma Kinase positive (ALK-positive), metastatic Non-small Cell Lung Cancer (NSCLC) or the requested drug is being used as adjuvant treatment following tumor resection of anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# ALOSETRON

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## Products Affected

- Alosetron Hydrochloride

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Diagnosis of severe diarrhea-predominant irritable bowel syndrome in female. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# ALUNBRIG

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## Products Affected

- Alunbrig

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |



# ARCALYST

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## Products Affected

- Arcalyst

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Cryopyrin-associated periodic syndromes: The member must have a documented diagnosis of a Cryopyrin-Associated Periodic Syndrome, including Familial Cold Autoinflammatory Syndrome, or Muckle-Wells Syndrome. Deficiency of interleukin-1 receptor antagonist: The member must have a documented diagnosis of deficiency of interleukin-1 receptor antagonist and Arcalyst is being used for maintenance of remission in patients weighing 10kg or more. Recurrent Pericarditis (RP): The member must have a documented diagnosis of RP and Arcalyst is being used to reduce the risk of recurrence. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# ARIKAYCE

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## Products Affected

- Arikayce

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Mycobacterium avium complex (MAC) lung disease: Diagnosis of Mycobacterium avium complex (MAC) lung disease. Used as part of a combination antibacterial drug regimen. Used in patients who do not achieve at least two negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy (e.g., a macrolide, a rifamycin, ethambutol, etc). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with an infectious disease specialist or pulmonologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

## ARMODAFINIL AND MODAFINIL

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### Products Affected

- Armodafinil

- Modafinil TABS

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | Coverage will not be approved for generalized fatigue, jet lag, or sleep-deprivation not associated with a covered diagnosis.                          |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of narcolepsy, excessive sleepiness associated with obstructive sleep apnea, or shift-work sleep disorder. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# AUGTYRO

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## Products Affected

- Augtyro

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Diagnosis of 1) locally advanced or metastatic ROS1-positive non-small cell lung cancer (NSCLC) or 2) neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors that a) are locally advanced, metastatic, or where surgical resection is likely to result in severe morbidity and b) have progressed following treatment or have no satisfactory alternative therapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescriber must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# AUSTEDO

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## Products Affected

- Austedo
- Austedo Xr
- Austedo Xr Patient Titration Kit

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Chorea Associated with Huntington's Disease: The member must have a documented diagnosis of chorea associated with Huntington's Disease.<br>Tardive Dyskinesia: The member must have a documented diagnosis of Tardive Dyskinesia. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# AVMAPKI FAKZYNJA

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## Products Affected

- Avmapki Fakzynja Co-pack

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | 1) Diagnosis of recurrent low-grade serous ovarian cancer (LGSOC) 2) Presence of a KRAS-mutation 3) Patient has received prior systemic therapy (e.g., chemotherapy). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# AYVAKIT

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## Products Affected

- Ayvakit

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Gastrointestinal Stromal Tumor (GIST): The member must have a documented diagnosis of PDGFRA Exon 18 mutation-positive, including PDGFRA D842V mutations, unresectable or metastatic GIST. Advanced Systemic Mastocytosis (AdvSM): The member must have a documented diagnosis of AdvSM, which includes aggressive systemic mastocytosis (ASM), systemic mastocytosis with an associated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL). Indolent Systemic Mastocytosis (ISM): The member must have a document diagnosis of Indolent Systemic Mastocytosis |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an allergist, immunologist, or oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# BALVERSA

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## Products Affected

- Balversa

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of locally advanced or metastatic urothelial carcinoma that has susceptible FGFR3 genetic alterations and 1) the member progressed during or following at least one line of prior systemic therapy and 2) the member had been treated with prior PD-1 inhibitor (e.g., nivolumab, pembrolizumab) or PD-L1 inhibitor therapy (e.g., avelumab) or the member is not a candidate for PD-1 or PD-L1 inhibitor therapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist or urologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |



# BENLYSTA

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## Products Affected

- Benlysta INJ 200MG/ML

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | Benlysta (belimumab) will not be approved as monotherapy, for members with severe active lupus nephritis or severe active central nervous system lupus, for members who are autoantibody negative, or in combination with other biologics or intravenous cyclophosphamide.             |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of active, autoantibody-positive (e.g., ANA, anti-ds-DNA, anti-Sm) systemic lupus erythematosus (SLE) or active lupus nephritis and is concurrently taking standard therapy (e.g., antimalarials, corticosteroids, or immunosuppressives). |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a nephrologist or rheumatologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# BERINERT

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## Products Affected

- Berinert

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of Hereditary Angioedema. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an allergist or immunologist.       |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# BESREMI

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## Products Affected

- Besremi

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.                                     |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of polycythemia vera. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# BEXAROTENE GEL

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## Products Affected

- Bexarotene GEL

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of cutaneous T-cell lymphoma with refractory or persistent disease after other therapies or with an intolerance to other therapies. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist or dermatologist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# BOSULIF

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## Products Affected

- Bosulif

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) chronic phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML), newly-diagnosed or resistant or intolerant to prior therapy or 2) accelerated, or blast phase Ph+ CML with resistance or intolerance to prior therapy |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# BRAFTOVI

## Products Affected

- Braftovi CAPS 75MG

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | Braftovi is not indicated for treatment of patients with wild-type BRAF melanoma or wild-type BRAF CRC.   |
| <b>Required Medical Information</b> | Metastatic Colorectal Cancer (CRC): The member must have a documented diagnosis of metastatic CRC with a BRAF V600E mutation after prior therapy and will be taken in combination with cetuximab. Melanoma (unresectable or metastatic): The member must have a documented diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation and will be taken in combination with binimetinib. Non-Small Cell Lung Cancer (NSCLC): The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation and will be taken in combination with binimetinib. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# BRUKINSA

## Products Affected

- Brukinsa

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) Mantle Cell Lymphoma (MCL) and has received at least one prior therapy or 2) Relapsed or refractory Marginal Zone Lymphoma (MZL) and has received at least one anti-CD20-based regimen, 3) Waldenstrom's Macroglobulinemia, 4) chronic lymphocytic leukemia (CLL), 5) small lymphocytic lymphoma (SLL) or 6) Relapsed or refractory follicular lymphoma (FL), in combination with obinutuzumab, after two or more lines of systemic therapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# CABOMETYX

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## Products Affected

- Cabometyx

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Advanced Renal Cell Carcinoma (RCC): The member must have a documented diagnosis of advanced renal cell carcinoma (RCC). Differentiated Thyroid Cancer (DTC): The member must have a documented diagnosis of locally advanced or metastatic DTC that has progressed following prior VEGFR-targeted therapy and are radioactive iodine-refractory or ineligible. Hepatocellular Carcinoma (HCC): The member must have a documented diagnosis of HCC and has had a documented failure, contraindication, or intolerance with sorafenib |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |



# CALQUENCE

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## Products Affected

- Calquence

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL): The member must have a documented diagnosis of CLL or SLL. Mantle Cell Lymphoma (MCL): The member must have a documented diagnosis of MCL and 1) has received at least one prior therapy OR 2) is previously untreated and is ineligible for autologous hematopoietic stem cell transplantation. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# CAPLYTA

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## Products Affected

- Caplyta

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of schizophrenia or bipolar depression. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a psychiatrist.                                   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# CAPRELSA

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## Products Affected

- Caprelsa

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an endocrinologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# CARGLUMIC

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## Products Affected

- Carglumic Acid

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have one of the following: 1) a documented diagnosis of chronic hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency. 2) a documented diagnosis of acute hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency and the requested drug is being used as adjunctive therapy. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# CAYSTON

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## Products Affected

- Cayston

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Cystic fibrosis (CF): Diagnosis of CF AND Patient has evidence of Pseudomonas aeruginosa in the lungs. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# CHOLBAM

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## Products Affected

- Cholbam

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | Cholbam will not be approved for members with extrahepatic manifestations of either bile acid synthesis disorders due to single enzyme defects (SEDs) or peroxisomal disorders (PDs), including Zellweger spectrum disorders.  |
| <b>Required Medical Information</b> | Bile Acid Synthesis Disorder: The member must have a documented diagnosis of bile acid synthesis disorders due to single enzyme defects (SEDs). Peroxisomal Disorders (PDs): The member must have a documented diagnosis of PDs, including Zellweger spectrum disorders, and exhibit manifestations of hepatic disease, steatorrhea, or complications from decreased fat soluble vitamin absorption and Cholbam is being used as adjunctive therapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# COBENFY

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## Products Affected

- Cobenfy

- Cobenfy Starter Pack

| <b>PA Criteria</b>                  | <b>Criteria Details</b>                           |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.               |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Diagnosis of schizophrenia.                       |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a psychiatrist. |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | Approve for continuation of prior therapy.        |

# COMETRIQ

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## Products Affected

- Cometriq

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of progressive, metastatic medullary thyroid cancer. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |



# COPIKTRA

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## Products Affected

- Copiktra

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): The member must have a documented diagnosis of relapsed or refractory CLL or SLL and has received at least two prior therapies. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# COSENTYX

## Products Affected

- Cosentyx
- Cosentyx Sensoready Pen
- Cosentyx Unoready

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | <p>Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe plaque psoriasis and has failed to respond to or has been unable to tolerate treatment with one of the following: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, or Coal tar.</p> <p>Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis. Non-radiographic Axial Spondyloarthritis: The member must have a documented diagnosis of active non-radiographic axial spondyloarthritis with objective signs of inflammation (e.g., C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.) and has had a minimum duration of one month trial and failure, contraindication, or intolerance to two NSAIDs (e.g., ibuprofen, meloxicam, naproxen) at maximally indicated doses. Enthesitis-related Arthritis (ERA): The member must have a documented diagnosis of active ERA and has had a minimum duration of one month trial and failure, contraindication, or intolerance to two NSAIDs (e.g., ibuprofen, meloxicam, naproxen). Hidradenitis Suppurativa: The member must have a documented diagnosis of moderate-to-severe hidradenitis suppurativa.</p> |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with a dermatologist or rheumatologist.  |
| <b>Coverage Duration</b>            | 2 years   |

|                       |     |
|-----------------------|-----|
| <b>Other Criteria</b> | N/A |
|-----------------------|-----|

# COTELLIC

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## Products Affected

- Cotellic

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | Cotellic is not indicated for treatment of patients with wild-type BRAF melanoma.  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) unresectable or metastatic melanoma with a BRAF V600E or V600K mutation and is being taken in combination with Zelboraf (vemurafenib) or 2) histiocytic neoplasm and is being used as monotherapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# DANZITEN

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## Products Affected

- Danziten

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | Approve for continuation of prior therapy.  |

# DAURISMO

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## Products Affected

- Daurismo

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of acute myelogenous leukemia (AML) and Daurismo is being used as first-line therapy in combination with low-dose cytarabine and the member meets one of the following: 1) is 75 years of age or older or 2) has comorbidities that make them ineligible for intensive induction chemotherapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# DIACOMIT

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## Products Affected

- Diacomit

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of seizures associated with Dravet syndrome and is concurrently taking clobazam. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a neurologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# DICHLORPHENAMIDE

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## Products Affected

- Dichlorphenamide

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |



# DICLOFENAC EPOLAMINE PATCH

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## Products Affected

- Diclofenac Epolamine

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | None   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of acute pain due to one of the following: minor strain, sprain, or contusion. |
| <b>Age Restrictions</b>             | None   |
| <b>Prescriber Restrictions</b>      | None   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | None   |

# DOPTELET

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## Products Affected

- Doptelet

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of one of the following:<br>1) Thrombocytopenia associated with chronic liver disease (CLD) and is scheduled to undergo a procedure<br>2) Thrombocytopenia with chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# DROXIDOPA

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## Products Affected

- Droxidopa

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of neurogenic orthostatic hypotension (NOH). |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# DUPIXENT

## Products Affected

- Dupixent

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | Dupixent will not be approved for the relief of acute bronchospasm or status asthmaticus.   |
| <b>Required Medical Information</b> | Atopic Dermatitis: The member must have a documented diagnosis of moderate to severe atopic dermatitis with a trial and failure of a minimum 30-day supply (or 14-day supply for topical corticosteroids), contraindication, or intolerance to at least one of the following: Medium or higher potency topical corticosteroid, Pimecrolimus cream, Tacrolimus ointment, or Eucrisa (crisaborole) ointment. Asthma: The member must have a documented diagnosis of moderate-to- severe asthma with an eosinophilic phenotype or is dependent on oral corticosteroids. Rhinosinusitis (chronic) with nasal polyposis: The member must have a documented diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) and is inadequately controlled on current treatment alone. Prurigo Nodularis: The member must have a document diagnosis of Prurigo Nodularis. Eosinophilic Esophagitis: Diagnosis of Eosinophilic Esophagitis. COPD: Diagnosis of COPD with an eosinophilic phenotype and requested medication is being used as add-on maintenance treatment. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with an allergist, dermatologist, immunologist, otolaryngologist, pulmonologist, or gastroenterologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# EMGALITY

## Products Affected

- Emgality

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Initial Approval: The member must have a documented diagnosis of one of the following: 1) Migraine and the member has had an inadequate response, contraindication, or inability to tolerate an appropriate trial after 4-weeks with at least one drug from the following classes: antidepressants (including but not limited to: amitriptyline, venlafaxine), antiepileptic drugs (including but not limited to: divalproex sodium, topiramate) or beta blockers (including but not limited to: propranolol, timolol) 2) Episodic Cluster headache. Subsequent Approval: The member has had a clinically significant reduction in migraine days per month or the frequency of weekly cluster headache attacks from baseline. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | Initial Approval: 6 months. Subsequent Approval: Life of Plan.  |
| <b>Other Criteria</b>               | N/A   |

# ENBREL

## Products Affected

- Enbrel INJ 25MG/0.5ML, 50MG/ML
- Enbrel Mini
- Enbrel Sureclick

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | <p>Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe plaque psoriasis and has failed to respond to or has been unable to tolerate treatment with one of the following: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, or Coal tar.</p> <p>Rheumatoid Arthritis (RA): The member must have a documented diagnosis of RA and has a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a documented diagnosis of PJIA and has a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine.</p> <p>Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis.</p> |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with a dermatologist or rheumatologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# EPIDIOLEX

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## Products Affected

- Epidiolex

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS), Dravet syndrome (DS) or tuberous sclerosis complex (TSC). |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a neurologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# ERIVEDGE

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## Products Affected

- Erivedge

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of metastatic basal cell carcinoma or locally advanced basal cell carcinoma that has recurred following surgery or the member is not a candidate for surgery, and not a candidate for radiation. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a dermatologist or oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |



# ERLEADA

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## Products Affected

- Erleada

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of one of the following:<br>1) non-metastatic, castration-resistant prostate cancer 2) metastatic hormone-sensitive prostate cancer. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist or urologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# ESBRIET

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## Products Affected

- Pirfenidone CAPS

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of idiopathic pulmonary fibrosis (IPF). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a pulmonologist.                                  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# EVEROLIMUS

## Products Affected

- Everolimus TABS 10MG, 2.5MG, 5MG, 7.5MG

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Advanced Hormone Receptor-Positive, HER2-Negative Breast Cancer (Advanced HR+ BC): The member must have a documented diagnosis of Advanced HR+ BC, the member is postmenopausal, concurrently taking exemestane and has a documented failure of letrozole or anastrozole. Advanced Renal Cell Carcinoma (ARCC): The member must have a documented diagnosis of ARCC and the member has a demonstrated disease progression or intolerance following a trial with sorafenib or sunitinib. Neuroendocrine Tumors (NET): The member must have a documented diagnosis of progressive neuroendocrine tumors of pancreatic origin (pNET) or progressive, well-differentiated, non-functional neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin, any of which are unresectable, locally advanced or metastatic. Renal Angiomyolipoma with Tuberous Sclerosis Complex (TSC): The member must have a documented presence of TSC and renal angiomyolipoma(s). Subependymal Giant Cell Astrocytoma (SEGA): The member must have a documented diagnosis of SEGA associated with TSC and the member is not a candidate for surgical resection. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a neurologist or oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# EVEROLIMUS FOR ORAL SUSPENSION

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## Products Affected

- Everolimus TBSO

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Partial-onset Seizures Associated with Tuberous Sclerosis Complex (TSC): The member must have a documented diagnosis of partial-onset seizures associated with TSC. Subependymal Giant Cell Astrocytoma (SEGA): The member must have a documented diagnosis of SEGA associated with TSC and the member is not a candidate for surgical resection. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a neurologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# EXKIVITY

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## Products Affected

- Exkivity

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations and has progressed on or after platinum-based chemotherapy. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# FASENRA

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## Products Affected

- Fasenra

- Fasenra Pen

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of severe asthma with an eosinophilic phenotype despite current treatment with both of the following medications: 1) inhaled corticosteroids 2) additional controller (Long-Acting Beta2-Agonist, Leukotriene Modifier, or Sustained Release Theophylline). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an asthma specialist (e.g., allergist, immunologist, pulmonologist).  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# FINTEPLA

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## Products Affected

- Fintepla

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of seizures associated with Dravet syndrome or Lennox-Gastaut syndrome. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a neurologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# FOTIVDA

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## Products Affected

- Fotivda

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of relapsed or refractory advanced renal cell carcinoma following two or more prior systemic therapies. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |



# FRUZAQLA

## Products Affected

- Fruzaqla

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Diagnosis of metastatic colorectal cancer. Patient has been previously treated with both of the following: A) Fluoropyrimidine-, oxaliplatin-, irinotecan-based chemotherapy, and B) Anti-VEGF biological therapy (e.g., bevacizumab, ramucirumab). One of the following: A) Patient does not have RAS wild type tumors, OR B) Both of the following: a) Patient has RAS wild type tumors, AND b) Trial and failure, contraindication, or intolerance to an anti-EGFR biological therapy (e.g., panitumumab, cetuximab). |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# GAVRETO

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## Products Affected

- Gavreto

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Non-small Cell Lung Cancer (NSCLC): The member must have a documented diagnosis of metastatic rearranged during transfection (RET) fusion-positive NSCLC. Thyroid Cancer: The member must have advanced or metastatic RET fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate) |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# GILOTRIF

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## Products Affected

- Gilotrif

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of one of the following:<br>1) Metastatic non-small cell lung cancer (NSCLC) and documented non-resistant epidermal growth factor receptor (EGFR) mutations<br>2) Metastatic, squamous cell NSCLC and documentation that the disease has progressed following platinum-based chemotherapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# GLP1

## Products Affected

- Mounjaro
- Ozempic
- Rybelsus
- Trulicity

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Type 2 Diabetes (initial): 1) Documented diagnosis of Type 2 Diabetes OR 2) Trial and failure of a minimum 90-day supply, contraindication, or intolerance to one product from any of the following drugs/classes: metformin-containing agent, DPP-4 inhibitors, DPP-4 inhibitor combinations, SGLT2 inhibitors, SGLT2 inhibitor combinations, alpha-glucosidase inhibitors, meglitinide analogues, sulfonylurea, or sulfonylurea combinations |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | Type 2 diabetes mellitus (Reauthorization): Patient demonstrates positive clinical response to therapy   |

# GOMEKLI

## Products Affected

- Gomekli

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | 1) Diagnosis of neurofibromatosis type 1 and 2) Has plexiform neurofibromas that are both of the following: a) inoperable and b) causing significant morbidity (e.g., disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | Approve for continuation of prior therapy.  |

# GROWTH HORMONE REPLACEMENT THERAPY

## Products Affected

- Genotropin

- Genotropin Miniquick

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Indications                  | All Medically-accepted Indications.  |
| Off-Label Uses               | N/A  |
| Exclusion Criteria           | N/A  |
| Required Medical Information | <p>Pediatric GHD, Initiation: Member has not attained epiphyseal closure as determined by X-ray, have failed to respond to at least TWO standard GH stimulation test, have documented gender-specific delayed bone age, have the height at initiation of therapy at greater than 2 standard deviations below normal mean for age and sex. Member must have one of the following: Chronic Renal Insufficiency prior to transplantation, Idiopathic Short Stature, Intrauterine Growth Retardation, Non-genetic GHD, Noonan Syndrome, Prader-Willi Syndrome, Short Stature Homeobox-containing gene (SHOX) deficiency, or Turner Syndrome. Pediatric GHD, Continuation: Documentation of the following is required: Medical history as it relates to growth, including any test results and growth chart, continuing care plan and an improvement in the annualized pre-treatment growth rate after the first six (6) months of therapy. Continuation of Therapy after Completion of Linear Growth: Member will be re-evaluated after GH treatments have been stopped for at least three (3) months to determine growth hormone status AND member must have failed to respond to at least one standard GH stimulation test. Acquired GHD: Member must have failed to respond to at least one standard GH stimulation test. AIDS Wasting Syndrome: Documented diagnosis of AIDS AND a weight loss of at least 10% from baseline weight OR a BMI of less than 20. Short Bowel Syndrome: Documented diagnosis of Short Bowel Syndrome from a gastroenterologist AND a documented dependence on IPN for nutritional support.</p> |
| Age Restrictions             | N/A  |
| Prescriber Restrictions      | N/A  |
| Coverage Duration            | 2 years  |

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|                       |     |
|-----------------------|-----|
| <b>Other Criteria</b> | N/A |
|-----------------------|-----|

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# HAEGARDA

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## Products Affected

- Haegarda

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of Hereditary Angioedema. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an allergist or immunologist.       |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |



# HERNEXEOS

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## Products Affected

- Hernexeos

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Diagnosis of non-squamous non-small cell lung cancer (NSCLC). Disease is one of the following: a) unresectable, b) metastatic. Presence of HER2 (ERBB2) tyrosine kinase domain activating mutations. Patient has received prior systemic therapy (e.g., chemotherapy). |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | Approve for continuation of prior therapy.   |

# HUMIRA

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## Products Affected

- Humira INJ 10MG/0.1ML, 20MG/0.2ML, 40MG/0.4ML, 40MG/0.8ML
- Humira Pediatric Crohns Disease Starter Pack INJ 0, 80MG/0.8ML
- Humira Pen
- Humira Pen-cd/uc/hs Starter
- Humira Pen-pediatric Uc Starter Pack
- Humira Pen-ps/uv Starter

| <b>PA Criteria</b>        | <b>Criteria Details</b>       |
|---------------------------|-------------------------------|
| <b>Indications</b>        | All FDA-approved Indications. |
| <b>Off-Label Uses</b>     | N/A                           |
| <b>Exclusion Criteria</b> | N/A                           |

|                                     |   |
|-------------------------------------|---|
| <b>Required Medical Information</b> | <p>Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Crohn's Disease (CD): The member must have a documented diagnosis CD and a trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroids (e.g., prednisone, methylprednisolone, or methotrexate. Ulcerative Colitis (UC): The member must have a documented diagnosis UC and a trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate [e.g., mesalamine (Asacol, Pentasa, Rowasa), Dipentum (olsalazine), sulfasalazine], azathioprine, or corticosteroids (e.g., prednisone, methylprednisolone). Hidradenitis Suppurativa: The member must have a documented diagnosis of moderate-to-severe hidradenitis suppurativa. Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe plaque psoriasis and has failed to respond to or has been unable to tolerate treatment with one of the following: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, or Coal tar. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of RA and has a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a documented diagnosis of PJIA and has a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine. Uveitis: The member must have a documented diagnosis of non-infectious uveitis.</p> |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with a dermatologist, gastroenterologist, ophthalmologist, or rheumatologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# IBRANCE

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## Products Affected

- Ibrance

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must 1) have a documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer and Ibrance is being used in combination with an aromatase inhibitor or 2) have a documented diagnosis of HR-positive, HER2- negative advanced or metastatic breast cancer with disease progression following endocrine therapy and documentation Ibrance (palbociclib) will be used in combination with Faslodex (fulvestrant). |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# IBTROZI

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## Products Affected

- Ibtrozi

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: 1) Locally advanced or 2) Metastatic. Presence of ROS1 rearrangement-positive tumor. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | Approve for continuation of prior therapy.   |

# ICATIBANT

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## Products Affected

- Icatibant Acetate

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | Icatibant will not be approved for members with acquired angioedema or concurrently taking an angiotensin converting enzyme (ACE) inhibitor.  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of Hereditary Angioedema (HAE) with a history of at least one severe attack in the past six months. For HAE Types 1 & 2, the diagnosis must be confirmed by laboratory testing (e.g., low C4 level, reduced C1 esterase inhibitor level or function). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an allergist, hematologist, or immunologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# ICLUSIG

## Products Affected

- Iclusig

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | Iclusig will not be approved for members with newly diagnosed chronic phase CML.  |
| <b>Required Medical Information</b> | Acute Lymphoblastic Leukemia (ALL): The member must be 1) T315I-positive or have a documented diagnosis of Philadelphia chromosome-positive ALL (Ph+ALL) for which no other tyrosine kinase inhibitor therapy is indicated or 2) newly diagnosed and in combination with chemotherapy. Chronic Myeloid Leukemia (CML): 1) The member must be T315I-positive or 2) have a documented diagnosis of accelerated phase, or blast phase CML for which no other kinase inhibitor therapy is indicated or 3) The member must have a diagnosis of Chronic phase (CP) chronic myeloid leukemia (CML) with resistance or intolerance to at least two prior kinase inhibitors. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# IDHIFA

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## Products Affected

- Idhifa

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |



# IMBRUVICA

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## Products Affected

- Imbruvica

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Chronic lymphocytic leukemia (CLL): Diagnosis of CLL. Waldenstrom's macroglobulinemia: Diagnosis of Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma. Small lymphocytic lymphoma (SLL): Diagnosis of SLL. Chronic graft versus host disease (cGVHD): Diagnosis of cGVHD AND trial and failure of one or more lines of systemic therapy (e.g., corticosteroids like prednisone or methylprednisolone, mycophenolate). |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist, oncologist, or transplant specialist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# IMKELDI

## Products Affected

- Imkeldi

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Chronic Myelogenous/Myeloid Leukemia (CML): Diagnosis of Philadelphia chromosome/BCR ABL-positive (Ph+/BCR ABL+) CML. Acute Lymphoblastic Leukemia/Acute Lymphoblastic Lymphoma (ALL): Diagnosis of Ph+/BCR ABL+ ALL. Myelodysplastic Disease (MDS)/Myeloproliferative Disease (MPD): Diagnosis of MDS/MPD. Aggressive Systemic Mastocytosis (ASM): Diagnosis of ASM. Hypereosinophilic Syndrome (HES) and/or Chronic Eosinophilic Leukemia (CEL): Diagnosis of at least one of the following: a) HES or b) CEL. Dermatofibrosarcoma Protuberans (DFSP): Diagnosis of unresectable, recurrent, or metastatic DFSP. Gastrointestinal Stromal Tumors (GIST): Diagnosis of GIST. All indications: Patient is unable to swallow generic imatinib tablet due to one of the following: a) Age, b) Physical impairment (e.g., difficulties with motor or oral coordination), c) Dysphagia, or d) Patient is using a feeding tube or nasal gastric tube. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | Approve for continuation of prior therapy.   |

# INCRELEX

## Products Affected

- Increlex

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | Coverage of Increlex will not be authorized for conditions resulting in secondary forms of IGF-1 deficiency that include, but are not limited to: GH deficiency, malnutrition, hypothyroidism, or chronic steroid therapy.  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of severe primary IGF-1 deficiency as defined by a height SD score less than or equal to -3.0, a basal IGF-1 SD score less than or equal to -3.0, normal or elevated GH level OR GH gene deletion and has developed neutralizing antibodies to GH. Radiographs documenting open epiphyses are required for members who are Tanner stage III or greater. |
| <b>Age Restrictions</b>             | The member must be 2 to 18 years of age.  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an endocrinologist.   |
| <b>Coverage Duration</b>            | Initial authorization is for 6 months. Subsequent authorizations are for 1 year.  |
| <b>Other Criteria</b>               | N/A   |

# INGREZZA

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## Products Affected

- Ingrezza

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of tardive dyskinesia or chorea associated with Huntington's disease. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# INLYTA

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## Products Affected

- Inlyta

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of advanced renal cell carcinoma and one of the following two requirements: 1) The member is using Inlyta as first line treatment in combination with avelumab or pembrolizumab 2) The member is using Inlyta as a single agent and has failed a trial of at least one systemic therapy (including but not limited to everolimus, Nexavar, sunitinib, Torisel, Votrient). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# INQOVI

## Products Affected

- Inqovi

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of myelodysplastic syndromes (MDS), including previously treated and untreated, de novo and secondary MDS with the following French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# INREBIC

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## Products Affected

- Inrebic

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# IRESSA

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## Products Affected

- Gefitinib

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) in tumors that have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |



# ITOVEBI

## Products Affected

- Itovebi

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | 1) Diagnosis of breast cancer. 2) Disease is locally advanced or metastatic. 3) Disease is PIK3CA-mutated, Hormone receptor (HR)-positive, Human epidermal growth-factor receptor 2 (HER2)-negative. 4) Used following recurrence on or after completing adjuvant endocrine therapy (e.g. goserelin, anastrozole, tamoxifen). 5) Used in combination with palbociclib and fulvestrant. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | Approve for continuation of prior therapy.   |

# IWILFIN

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## Products Affected

- Iwilfin

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Diagnosis of high-risk neuroblastoma (HRNB) with at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescriber must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | Approve for continuation of prior therapy.  |

# JAKAFI

## Products Affected

- Jakafi

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Chronic Graft-versus-host Disease (GVHD): The member must have a documented diagnosis of chronic GVHD after failure of one or two lines of systemic therapy. Myelofibrosis: The member must have a documented diagnosis of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis. Polycythemia Vera: The member must have a documented diagnosis of polycythemia vera with an inadequate response, contraindication, or inability to tolerate hydroxyurea. Steroid-Refractory Acute Graft-versus-host Disease (GVHD): The member must have a document diagnosis of steroid-refractory acute GVHD. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 Years  |
| <b>Other Criteria</b>               | For Myelofibrosis: Subsequent authorization requires documentation of spleen size reduction or symptomatic improvement.  |

# JAYPIRCA

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## Products Affected

- Jaypirca

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of relapsed or refractory mantle cell lymphoma (MCL) or chronic lymphocytic leukemia or small lymphocytic lymphoma (CLL/SLL). Documentation the member has received at least two prior lines of systemic therapies. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# KALYDECO

## Products Affected

- Kalydeco

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | Kalydeco is not effective in patients with cystic fibrosis who are homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of cystic fibrosis (CF) and have one mutation in the CFTR gene that is responsive to Kalydeco based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared cystic fibrosis mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. |
| <b>Age Restrictions</b>             | Granules: The member must be 1 month of age or older.   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# KERENDIA

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## Products Affected

- Kerendia

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of chronic kidney disease associated with type 2 diabetes or heart failure with left ventricular ejection fraction greater than or equal to 40%. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# KESIMPTA

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## Products Affected

- Kesimpta

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a neurologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# KISQALI

## Products Affected

- Kisqali
- Kisqali Femara 200 Dose
- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer in combination with a) an aromatase inhibitor as initial endocrine-based therapy or b) fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy in women or in men or 2) HR-positive, HER2-negative stage II and III early breast cancer at high risk of recurrence with a) an aromatase inhibitor. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |



# KORLYM

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## Products Affected

- Korlym

- Mifepristone TABS 300MG

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of hyperglycemia secondary to hypercortisolism with endogenous Cushing's syndrome and type 2 diabetes mellitus OR glucose intolerance AND has failed surgery OR is not a candidate for surgery. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# KOSELUGO

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## Products Affected

- Koselugo CAPS

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of Neurofibromatosis type 1 and have symptomatic, inoperable plexiform neurofibromas. |
| <b>Age Restrictions</b>             | The member must be 2 to 17 years of age.  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a neurologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# KRAZATI

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## Products Affected

- Krazati

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is 1) locally advanced or metastatic 2) KRAS G12C-mutated and 3) patient has received at least one prior systemic therapy (e.g., chemotherapy, immunotherapy). |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# LAPATINIB

## Products Affected

- Lapatinib Ditosylate

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Indications                  | All Medically-accepted Indications.  |
| Off-Label Uses               | N/A  |
| Exclusion Criteria           | N/A  |
| Required Medical Information | For estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2) overexpressing advanced or metastatic breast cancer, the member must meet ALL of the following criteria: 1) Documented diagnosis of HER2 overexpressing advanced or metastatic breast cancer. 2) The member has failed prior therapy with an anthracycline and a taxane chemotherapeutic agent. 3) The member has failed prior therapy with trastuzumab. 4) The member is concurrently treated with capecitabine.<br>Hormone Receptor Positive Metastatic Breast Cancer in Post-menopausal Women: The member must have a documented diagnosis of hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor and is concurrently being treated with letrozole |
| Age Restrictions             | N/A  |
| Prescriber Restrictions      | The prescribing physician must be an oncologist.   |
| Coverage Duration            | 2 years  |
| Other Criteria               | N/A  |

# LAZCLUZE

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## Products Affected

- Lazcluze

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | 1) Diagnosis of non-small cell lung cancer (NSCLC). 2) Disease is locally advanced or metastatic. 3) Used as first line treatment of NSCLC. 4) Used in combination with amivantamab. 5) Presence of epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | Approve for continuation of prior therapy.   |

# LENALIDOMIDE

## Products Affected

- Lenalidomide

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Follicular Lymphoma (FL): The member must have a documented diagnosis of previously treated FL and the requested drug is being used in combination with a rituximab product. Mantle Cell Lymphoma (MCL): The member must have a documented diagnosis of MCL and the member's disease has relapsed or progressed after two prior therapies, one of which included Velcade (bortezomib). Marginal Zone Lymphoma (MZL): The member must have a documented diagnosis of previously treated MZL and the requested drug is being used in combination with a rituximab product. Multiple Myeloma: The member must have a documented diagnosis of multiple myeloma and requested drug is being used in combination with dexamethasone or as maintenance therapy in a member following autologous hematopoietic stem cell transplantation. Myelodysplastic Syndrome (MDS): The member must have a documented diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk MDS associated with the 5q-deletion cytogenetic abnormality. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# LENVIMA

## Products Affected

- Lenvima 10 Mg Daily Dose
- Lenvima 12mg Daily Dose
- Lenvima 14 Mg Daily Dose
- Lenvima 18 Mg Daily Dose
- Lenvima 20 Mg Daily Dose
- Lenvima 24 Mg Daily Dose
- Lenvima 4 Mg Daily Dose
- Lenvima 8 Mg Daily Dose

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Indications                  | All FDA-approved Indications.   |
| Off-Label Uses               | N/A   |
| Exclusion Criteria           | N/A   |
| Required Medical Information | Advanced Endometrial Carcinoma: The member must have a documented diagnosis of advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), who have disease progression following prior systemic therapy and are not candidates for curative surgery or radiation and it will be used in combination with Keytruda (pembrolizumab). Advanced Renal Cell Carcinoma (ARCC): The member must have a documented diagnosis of ARCC and 1) has had one prior antiangiogenic therapy and is being used in combination with Afinitor (everolimus) or 2) being used as first-line treatment in combination with pembrolizumab. Hepatocellular carcinoma (HCC): The member must have a documented diagnosis of unresectable hepatocellular carcinoma. Thyroid Cancer: The member must have a documented diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer. |
| Age Restrictions             | N/A   |
| Prescriber Restrictions      | The prescribing physician must be an oncologist.  |
| Coverage Duration            | 2 years   |
| Other Criteria               | N/A   |

# LIDOCAINE TRANSDERMAL PATCHES

## Products Affected

- Lidocaine PTCH 5%

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | For Postherpetic Neuralgia or Diabetic Neuropathy, the member must have had a failure, adverse reaction, or contraindication to gabapentin. Lidocaine transdermal patches will also be approved for members who are not candidates for opioid or other oral pain management therapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | Coverage will be authorized for new members if their pain is currently well-controlled on lidocaine transdermal patches.   |



# LIVTENCITY

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## Products Affected

- Livtency

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member, weighing 35kg or more, must have a documented diagnosis of post-transplant cytomegalovirus (CMV) infection/disease, that is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir, or foscarnet. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# LONSURF

## Products Affected

- Lonsurf

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Metastatic Colorectal Cancer (mCRC): The member must have a documented diagnosis of mCRC and has been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-vascular endothelial growth factor (VEGF) biological therapy, and if RAS wild-type, an anti-epidermal growth factor receptor (EGFR) therapy. Metastatic Gastric or Gastroesophageal Junction Adenocarcinoma: The member must have a documented diagnosis of metastatic gastric or gastroesophageal junction adenocarcinoma and has been previously treated with at least two prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# LORBRENA

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## Products Affected

- Lorbrena

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# LUMAKRAS

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## Products Affected

- Lumakras

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC) and has received at least one prior systemic therapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# LYBALVI

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## Products Affected

- Lybalvi

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of schizophrenia or Bipolar I disorder. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a psychiatrist.                                   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# LYNPARZA

## Products Affected

- Lynparza TABS

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Indications                  | All FDA-approved Indications.   |
| Off-Label Uses               | N/A   |
| Exclusion Criteria           | N/A   |
| Required Medical Information | <p>Breast Cancer: Diagnosis of deleterious gBRCA-mutated, HER2-negative 1) metastatic breast cancer and has been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting and, if hormone receptor-positive, the member should have prior endocrine therapy or contraindication to or inability to tolerate endocrine therapy or 2) high risk early breast cancer, has been treated with neoadjuvant or adjuvant chemotherapy. Ovarian Cancer: 1) Maintenance treatment of deleterious or suspected deleterious germline or somatic BRCA-mutated advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in complete or partial response to first-line platinum-based chemotherapy 2) Maintenance treatment of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in combination with bevacizumab and the member is in complete or partial response to first-line platinum-based chemotherapy and the members cancer is associated with homologous recombination deficiency (HRD)-positive status 3) Maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and the member is in complete or partial response to platinum-based chemotherapy. Pancreatic Cancer: The member has a diagnosis of deleterious or suspected deleterious germline BRCA-mutated metastatic pancreatic adenocarcinoma and no disease progression after at least 16 weeks of first-line platinum-based chemotherapy. Prostate Cancer: The member has a documented diagnosis of deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer (mCRPC) who have progressed following prior treatment with enzalutamide or abiraterone or a documented diagnosis of deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC) and is being used in combination with abiraterone and prednisone or prednisolone.</p> |
| Age Restrictions             | N/A   |

|                                |  |
|--------------------------------|--|
| <b>Prescriber Restrictions</b> | The prescribing physician must be an oncologist. |
| <b>Coverage Duration</b>       | 2 years  |
| <b>Other Criteria</b>          | N/A  |

# LYTGOBI

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## Products Affected

- Lytgobi

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of previously treated, unresectable, locally advanced or metastatic intrahepatic cholangiocarcinoma harboring fibroblast growth factor receptor 2 (FGFR2) gene fusions or other rearrangements |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |



# MAVYRET

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## Products Affected

- Mavyret

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Criteria will be applied consistent with current AASLD-IDSA guidance.                                      |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist. |
| <b>Coverage Duration</b>            | Criteria will be applied consistent with current AASLD-IDSA guidance.                                      |
| <b>Other Criteria</b>               | N/A  |

# MEDICATIONS FOR THE TREATMENT OF PULMONARY HYPERTENSION

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## Products Affected

- Adempas
- Alyq
- Ambrisentan
- Bosentan
- Opsumit
- Orenitram
- Orenitram Titration Kit Month 1
- Orenitram Titration Kit Month 2
- Orenitram Titration Kit Month 3
- Sildenafil Citrate TABS 20MG
- Tadalafil TABS 20MG
- Tracleer TBSO
- Ventavis

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Pulmonary arterial hypertension (PAH) The member must have a documented diagnosis of pulmonary arterial hypertension as confirmed by right heart catheterization. Chronic thromboembolic pulmonary hypertension (CTEPH) Diagnosis of persistent/recurrent CTEPH (after surgical treatment or inoperable) |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a cardiologist or pulmonologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# MEKINIST

## Products Affected

- Mekinist

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | Mekinist will not be approved as a single agent for members who have received prior BRAF-inhibitor therapy.  |
| <b>Required Medical Information</b> | Single Agent: The member must have a documented diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutations. In Combination with Tafinlar: The member must have a documented diagnosis of one of the following: 1) Unresectable or metastatic melanoma with a BRAF V600E or V600K mutation. 2) Melanoma with a BRAF V600E or V600K mutation and involvement of lymph node(s) following complete resection. 3) Metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation. 4) Locally advanced or metastatic anaplastic thyroid cancer (ATC) with a BRAF V600E mutation with no satisfactory locoregional treatment options. 5) Unresectable or metastatic solid tumors with BRAF V600E mutation and has progressed following prior treatment. 6) low grade glioma with BRAF V600E mutation that requires systemic therapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# MEKTOVI

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## Products Affected

- Mektovi

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, and will be taken in combination with encorafenib or 2) metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation, and will be taken in combination with encorafenib. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# MIGLUSTAT

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## Products Affected

- Miglustat

- Yargesa

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of mild-to-moderate Gaucher disease type 1 and enzyme replacement therapy is not a therapeutic option (e.g. allergy, hypersensitivity, poor venous access). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

## MISCELLANEOUS INJECTABLES

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### Products Affected

- Abelcet
- Acyclovir Sodium INJ 50MG/ML
- Amphotericin B INJ
- Amphotericin B Liposome

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Diagnosis of an FDA-approved indication not otherwise excluded from Part D. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# MODEYSO

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## Products Affected

- Modeyso

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Diagnosis of diffuse midline glioma. Disease is confirmed by the presence of H3 K27M mutation. Disease has progressed following prior therapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | Approve for continuation of prior therapy.   |

# NAYZILAM

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## Products Affected

- Nayzilam

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of a seizure disorder requiring acute treatment. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a neurologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |



# NERLYNX

## Products Affected

- Nerlynx

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Extended Adjuvant Treatment of Early-stage Breast Cancer: The member must have a documented diagnosis of early stage human epidermal growth receptor type 2 (HER2)-positive breast cancer and has had previous adjuvant treatment with Herceptin-based therapy. Advanced or Metastatic Breast Cancer: The member must have a documented diagnosis of advanced or metastatic HER2-positive breast cancer, is using Nerlynx in combination with capecitabine, and has received two or more prior anti-HER2 based regimens. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# NINLARO

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## Products Affected

- Ninlaro

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of multiple myeloma and Ninlaro is being used in combination with Revlimid (lenalidomide) and dexamethasone in patients who have received at least one prior therapy. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# NITISINONE

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## Products Affected

- Nitisinone

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of hereditary tyrosinemia type-1 (HT-1). |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# NUBEQA

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## Products Affected

- Nubeqa

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of non-metastatic castration-resistant prostate cancer or metastatic hormone-sensitive prostate cancer. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist or urologist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# NUEDEXTA

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## Products Affected

- Nuedexta

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of pseudobulbar affect (PBA). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# NUPLAZID

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## Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of Parkinson's disease and have hallucinations and delusions associated with Parkinson's disease psychosis. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The medication must be prescribed by or in consultation with a neurologist or psychiatrist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# NURTEC

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## Products Affected

- Nurtec

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) acute migraine and has had an inadequate response, intolerance, or contraindication to at least one triptan medication OR 2) episodic migraine. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# ODOMZO

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## Products Affected

- Odomzo

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of locally advanced basal cell carcinoma and one of the following: 1) Documentation of disease recurrence following surgery or radiation therapy or 2) Documentation that the member is not a candidate for surgery or radiation therapy. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |



# OFEV

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## Products Affected

- Ofev

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of one of the following: 1) idiopathic pulmonary fibrosis (IPF) 2) systemic sclerosis-associated interstitial lung disease (SSc-ILD) or 3) chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a pulmonologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# OGSIVEO

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## Products Affected

- Ogsiveo

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | 1) Diagnosis of progressing desmoid tumors and 2) Patient requires systemic treatment. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescriber must be an oncologist or sarcoma specialist.                            |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

## OJEMDA

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### Products Affected

- Ojemda

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Diagnosis of pediatric low-grade glioma. Disease is relapsed or refractory. Disease has a BRAF fusion or rearrangement, or BRAF V600 mutation. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# OJJAARA

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## Products Affected

- Ojjaara

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Diagnosis of intermediate or high-risk myelofibrosis (MF), including primary MF or secondary MF [post-polycythemia vera (PV) and post-essential thrombocythemia (ET)], in adults with anemia. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# ONUREG

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## Products Affected

- Onureg

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of acute myeloid leukemia and has achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy and are not able to complete intensive curative therapy. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# OPIPZA

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## Products Affected

- Opipza

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | 1) Diagnosis of schizophrenia or 2) Diagnosis of major depressive disorder (MDD) and being used as adjunctive treatment or 3) Drug is being used for irritability associated with autistic disorder in pediatric patients or 4) Diagnosis of Tourette's disorder in pediatric patients |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a psychiatrist or a neurologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | Approve for continuation of prior therapy.   |

# ORENCIA

## Products Affected

- Orencia INJ 125MG/ML, 50MG/0.4ML, 87.5MG/0.7ML

- Orencia Clickject

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | <p>Rheumatoid Arthritis (RA): The member must have a documented diagnosis RA and a trial and failure, contraindication, or intolerance to one of the following conventional therapies: methotrexate, leflunomide, sulfasalazine.</p> <p>Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a documented diagnosis of PJIA and has a trial and failure, contraindication, or intolerance to one of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine</p> <p>Psoriatic Arthritis (PsA): The member must have a documented diagnosis of psoriatic arthritis.</p> |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with a dermatologist, rheumatologist, oncologist, or transplant specialist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# ORGOVYX

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## Products Affected

- Orgovyx

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of advanced prostate cancer. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist or urologist.            |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |



# ORKAMBI

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## Products Affected

- Orkambi

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of cystic fibrosis (CF) and have documentation that the member is homozygous for the F508del mutation on both alleles of the CFTR gene. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# ORSERDU

## Products Affected

- Orserdu

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have documented diagnosis of advanced or metastatic breast cancer that is estrogen receptor (ER)-positive and human epidermal growth factor receptor 2 (HER2)-negative. Documentation that the member has estrogen receptor (ESR1) mutated disease. Disease has progressed following at least one line of endocrine therapy [e.g., Faslodex (fulvestrant), Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# OTEZLA

## Products Affected

- Otezla

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Psoriatic Arthritis (PsA): The member must have a documented diagnosis of psoriatic arthritis. Plaque psoriasis (PsO): The member must have a documented diagnosis of plaque psoriasis and has failed to respond to or has been unable to tolerate treatment with one of the following: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, or Coal tar. Oral ulcers associated with Behcet's Disease: The member must have a documented diagnosis of Behcet's Disease. The member has active oral ulcers. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with a dermatologist or rheumatologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# PEMAZYRE

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## Products Affected

- Pemazyre

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) unresectable, locally advanced or metastatic Cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement and has been previously treated or 2) relapsed or refractory myeloid/lymphoid neoplasms (MLNs) with fibroblast growth factor receptor 1 (FGFR1) rearrangement. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# PIQRAY

## Products Affected

- Piqray 200mg Daily Dose
- Piqray 250mg Daily Dose
- Piqray 300mg Daily Dose

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Indications                  | All FDA-approved Indications.  |
| Off-Label Uses               | N/A  |
| Exclusion Criteria           | N/A  |
| Required Medical Information | The member must meet the following criteria: 1) The member must have a documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer. 2) The member has progressed on or after an endocrine-based regimen. 3) Piqray is being used in combination with fulvestrant. |
| Age Restrictions             | N/A  |
| Prescriber Restrictions      | The prescribing physician must be an oncologist.   |
| Coverage Duration            | 2 years  |
| Other Criteria               | N/A  |

# PIRFENIDONE

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## Products Affected

- Pirfenidone TABS

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of idiopathic pulmonary fibrosis (IPF). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a pulmonologist.                                  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# POMALYST

## Products Affected

- Pomalyst

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Kaposi Sarcoma: The member must have a documented diagnosis Kaposi sarcoma (KS) or AIDS-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART). Multiple Myeloma: The member must have a documented diagnosis of multiple myeloma and has received at least two prior therapies including Revlimid (lenalidomide) and a proteasome inhibitor (including but not limited to: Kyprolis, Ninlaro, or Velcade) and has demonstrated disease progression on or within 60 days of completion of the last therapy AND Pomalyst is being used in combination with dexamethasone. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# PRALUENT

## Products Affected

- Praluent

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must meet the following criteria: 1) Member has an elevated LDL-C level while being treated with a high-intensity statin (i.e. atorvastatin or rosuvastatin) or has an elevated LDL-C level and a contraindication/intolerance to statin therapy. 2) The member must have a documented diagnosis of one of the following: a) Cardiovascular disease b) Primary hyperlipidemia including Heterozygous Familial Hypercholesterolemia (HeFH) as confirmed by genetic testing or clinical criteria. c) Homozygous Familial Hypercholesterolemia (HoFH) as confirmed by genetic testing or clinical criteria. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |



# PREVYMIS

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## Products Affected

- Prevymis PACK

- Prevymis TABS

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have documentation of 1) having had, or is scheduled to receive, an allogeneic hematopoietic stem cell transplant (HSCT) and the member is at risk for cytomegalovirus (CMV) infection or 2) having had, or is scheduled to receive, a kidney transplant and the member is at risk for cytomegalovirus (CMV) infection |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# PROLASTIN

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## Products Affected

- Prolastin-c

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of hereditary deficiency of alpha-1 antitrypsin with clinical evidence of emphysema. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# PROLIA

## Products Affected

- Prolia

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Coverage of Prolia (denosumab) for the treatment of osteoporosis in men and postmenopausal women will be authorized when the following criteria are met: 1) The member is at high risk of fracture defined as a history of osteoporotic fracture or multiple risk factors for fracture and a T score less than or equal to -2.0 as evidenced via bone density scan or 2) the member has had an inadequate response to, or is unable to tolerate therapy with at least one of the traditional osteoporosis treatments [including but not limited to: alendronate (Fosamax), calcitonin (Miacalcin), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel), zoledronic acid (Reclast)] or 3) the member is a female at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer and is using Prolia (denosumab) as a treatment to increase bone mass. Coverage of Prolia may also be authorized for 1) men at high risk of fracture who are receiving androgen deprivation therapy for non-metastatic prostate cancer or 2) treatment for glucocorticoid-induced osteoporosis in men and women at high risk for fracture. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# PROMACTA

## Products Affected

- Eltrombopag Olamine

- Promacta

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Chronic Immune (idiopathic) Thrombocytopenic Purpura (ITP): The member must have a documented diagnosis of Chronic ITP and has had an insufficient response or intolerance to corticosteroids, immunoglobulins, or splenectomy. Severe Aplastic Anemia: 1) The member must have a documented diagnosis of severe aplastic anemia and 2) will be taken in combination with, or in those who have had an insufficient response with, standard immunosuppressive therapy. Thrombocytopenia with Chronic Hepatitis C: The member must have a documented diagnosis of thrombocytopenia with chronic hepatitis C infection. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# PYRUKYND

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## Products Affected

- Pyrukynd

- Pyrukynd Taper Pack

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of hemolytic anemia with pyruvate kinase deficiency. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The medication must be prescribed by or in consultation with a hematologist.                     |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# QINLOCK

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## Products Affected

- Qinlock

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of advanced gastrointestinal stromal tumor (GIST) who have received prior treatment with 3 or more kinase inhibitors, including imatinib. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# QUININE SULFATE

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## Products Affected

- Quinine Sulfate CAPS 324MG

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | Coverage will not be approved for the treatment or prevention of nocturnal leg cramps.           |
| <b>Required Medical Information</b> | The member is using the medication for treatment of uncomplicated Plasmodium falciparum malaria. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# RADICAVA ORAL SUSPENSION

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## Products Affected

- Radicava Ors

- Radicava Ors Starter Kit

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of amyotrophic lateral sclerosis (ALS). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a neurologist.                                    |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |



# REPATHA

## Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must meet the following criteria: 1) Member has an elevated LDL-C level while being treated with a high-intensity statin (i.e. atorvastatin or rosuvastatin) or has an elevated LDL-C level and a contraindication/intolerance to statin therapy. 2) The member must have a documented diagnosis of one of the following: a) Cardiovascular disease b) Primary hyperlipidemia including Heterozygous Familial Hypercholesterolemia (HeFH) as confirmed by genetic testing or clinical criteria. c) Homozygous Familial Hypercholesterolemia (HoFH) as confirmed by genetic testing or clinical criteria. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# RETEVMO

## Products Affected

- Retevmo

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Non-Small Cell Lung Cancer: The member must have a documented diagnosis of metastatic RET fusion-positive non-small cell lung cancer (NSCLC). RET-mutant Medullary Thyroid Cancer: The member must have a documented diagnosis of advanced or metastatic RET-mutant medullary thyroid cancer (MTC) who require systemic therapy. RET Fusion-Positive Thyroid Cancer: The member must have a documented diagnosis of advanced or metastatic RET fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate). Solid Tumors: The member must have a documented diagnosis of locally advanced or metastatic solid tumors with a RET gene fusion that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# RETINOIDS FOR THE TOPICAL TREATMENT OF ACNE VULGARIS AND PSORIASIS

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## Products Affected

- Adapalene GEL
- Avita
- Tazarotene CREA
- Tazarotene GEL
- Tretinoin CREA
- Tretinoin Microsphere

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | Coverage of topical acne products will not be authorized for cosmetic purposes.  |
| <b>Required Medical Information</b> | For all retinoids, the member must have a documented diagnosis of acne vulgaris, comedones (white heads), or actinic keratosis. Tazarotene may also be covered if the member has a physician-documented diagnosis of plaque psoriasis or documented diagnosis of skin cancer provided effective treatment with tazarotene is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature. |
| <b>Age Restrictions</b>             | This criterion only applies to members age 26 or older. Authorization is not required for members 25 years of age or younger.  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# REVLIMID

## Products Affected

- Revlimid

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Follicular Lymphoma (FL): The member must have a documented diagnosis of previously treated FL and the requested drug is being used in combination with a rituximab product. Mantle Cell Lymphoma (MCL): The member must have a documented diagnosis of MCL and the member's disease has relapsed or progressed after two prior therapies, one of which included Velcade (bortezomib). Marginal Zone Lymphoma (MZL): The member must have a documented diagnosis of previously treated MZL and the requested drug is being used in combination with a rituximab product. Multiple Myeloma: The member must have a documented diagnosis of multiple myeloma and the requested drug is being used in combination with dexamethasone or as maintenance therapy in a member following autologous hematopoietic stem cell transplantation. Myelodysplastic Syndrome (MDS): The member must have a documented diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk MDS associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# REVUFORJ

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## Products Affected

- Revuforj

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Diagnosis of relapsed or refractory acute leukemia with a lysine methyltransferase 2A gene (KMT2A) translocation. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | Approve for continuation of prior therapy.  |

# REZLIDHIA

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## Products Affected

- Rezlidhia

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of relapsed or refractory acute myeloid leukemia and documentation cancer has susceptible IDH1 mutation as detected by a Food and Drug Administration-approved test |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with an oncologist or a hematologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# REZUROCK

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## Products Affected

- Rezurock

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Chronic graft versus host disease (cGVHD): Diagnosis of cGVHD. Trial and failure of two or more lines of systemic therapy [e.g., corticosteroids (e.g., prednisone, methylprednisolone), mycophenolate]. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with one of the following: hematologist, oncologist, or physician experienced in the management of transplant patients.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# RINVOQ

## Products Affected

- Rinvoq

- Rinvoq Lq

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Indications                  | All FDA-approved Indications.   |
| Off-Label Uses               | N/A   |
| Exclusion Criteria           | N/A   |
| Required Medical Information | <p>Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis.</p> <p>Atopic Dermatitis: Diagnosis of moderate to severe atopic dermatitis with 1) a trial and failure of a minimum 30-day supply (or 14-day supply for topical corticosteroids), contraindication, or intolerance to at least one of the following: Medium or higher potency topical corticosteroid, Pimecrolimus cream, Tacrolimus ointment, Eucrisa (crisaborole) ointment and 2) a trial and failure of a minimum 12-week supply of at least one systemic drug product for the treatment of atopic dermatitis (examples include, but are not limited to, tralokinumab-ldrm, dupilumab, etc.).</p> <p>Psoriatic Arthritis: Diagnosis of psoriatic arthritis and has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Enbrel, Humira).</p> <p>Rheumatoid Arthritis: The member must 1) diagnosis of Rheumatoid Arthritis and 2) has a trial and failure, contraindication, or intolerance (T/F/C/I) to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine and 3) has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Enbrel, Humira).</p> <p>Ulcerative Colitis (UC): The member must 1) diagnosis UC and 2) has a trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6- mercaptopurine, aminosalicylate [e.g., mesalamine, olsalazine, sulfasalazine], azathioprine, or corticosteroids (e.g., prednisone, methylprednisolone) and 3) has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Humira).</p> <p>Non-radiographic Axial Spondyloarthritis: Diagnosis of Non-radiographic Axial Spondyloarthritis and has an inadequate response or intolerance to TNF blocker therapy.</p> <p>Crohn's disease: 1) Diagnosis of moderate to severe CD and 2) T/F/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), methotrexate and 3) inadequate response or intolerance to one of more TNF blockers.</p> |
| Age Restrictions             | N/A   |



|                                |   |
|--------------------------------|---|
| <b>Prescriber Restrictions</b> | Prescribed by or in consultation with a allergist/immunologist, dermatologist, gastroenterologist, or rheumatologist. |
| <b>Coverage Duration</b>       | 2 years   |
| <b>Other Criteria</b>          | N/A   |

# ROMVIMZA

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## Products Affected

- Romvimza

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | 1) Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT) and<br>2) Surgical resection will potentially cause worsening functional limitation or severe morbidity. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | Approve for continuation of prior therapy.  |

# ROZLYTREK

## Products Affected

- Rozlytrek

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Non-small Cell Lung Cancer (NSCLC): The member must have a documented diagnosis of metastatic NSCLC with ROS1-positive tumors. Solid Tumors: The member must have a documented diagnosis of solid tumors that 1) have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, 2) are metastatic or where surgical resection is likely to result in severe morbidity, and 3) have progressed following treatment or have no satisfactory alternative therapy. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# RUBRACA

## Products Affected

- Rubraca

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | Rubraca will not be approved for concurrent use with other chemotherapy agents.  |
| <b>Required Medical Information</b> | Recurrent Ovarian Cancer (maintenance): The member must have a documented diagnosis of deleterious BRCA mutation (germline and/or somatic)- associated recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and is in a complete or partial response to platinum-based chemotherapy. Prostate Cancer: The member must have a documented diagnosis of deleterious BRCA mutation (germline and/or somatic)-associated metastatic castration-resistant prostate cancer (mCRPC) who have been treated with androgen receptor directed therapy and a taxane-based chemotherapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# RYDAPT

## Products Affected

- Rydapt

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | Rydapt will not be approved as single-agent induction therapy for the treatment of patients with AML.   |
| <b>Required Medical Information</b> | Acute Myeloid Leukemia (AML): The member must have a documented diagnosis of AML that is FLT3 mutation-positive and Rydapt is being used as first-line therapy in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation. Mast Cell Leukemia (MCL): The member must have a documented diagnosis of MCL.<br>Systemic Mastocytosis: The member must have a documented diagnosis of aggressive systemic mastocytosis (ASM) or systemic mastocytosis with associated hematological neoplasm (SM-AHN). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist or an allergist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# SAPROPTERIN

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## Products Affected

- Sapropterin Dihydrochloride
- Zelvysia

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of hyperphenylalaninemia (HPA) due to tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a specialist in metabolic diseases or a geneticist.   |
| <b>Coverage Duration</b>            | Initial authorization is for 8 weeks. Subsequent authorization is for 2 years.  |
| <b>Other Criteria</b>               | Coverage will be authorized for continuing therapy if the member has experienced improvement.   |

# SCSEMBLIX

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## Products Affected

- Scemblix

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP) and previously treated with two or more tyrosine kinase inhibitors (TKIs) or has a documented T315I mutation. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# SIGNIFOR

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## Products Affected

- Signifor

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of Cushing's disease and pituitary surgery is not an option or has not been curative. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an endocrinologist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |



# SIRTURO

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## Products Affected

- Sirturo

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of pulmonary multi-drug resistant tuberculosis (MDR-TB) and Sirturo is being used in combination with at least three other drugs to which the member's MDR-TB isolate has been shown to be susceptible in vitro. If in vitro testing results are unavailable, treatment may be initiated with Sirturo in combination with at least four other drugs to which the member's MDR-TB isolate is likely to be susceptible. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# SKYRIZI

## Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML, 600MG/10ML
- Skyrizi Pen

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Indications                  | All FDA-approved Indications.  |
| Off-Label Uses               | N/A  |
| Exclusion Criteria           | N/A  |
| Required Medical Information | <p>Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe plaque psoriasis and has failed to respond to or has been unable to tolerate treatment with one of the following: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, or Coal tar. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis. Crohn's disease: 1) diagnosis of moderate to severe CD and 2) trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), methotrexate. Ulcerative Colitis: Diagnosis of moderately to severely active UC and a trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate [e.g., mesalamine, olsalazine, sulfasalazine, azathioprine, or corticosteroids (e.g., prednisone, methylprednisolone).</p> |
| Age Restrictions             | N/A  |
| Prescriber Restrictions      | Prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist.  |
| Coverage Duration            | 2 years  |
| Other Criteria               | N/A  |

# SODIUM OXYBATE

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## Products Affected

- Sodium Oxybate

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of narcolepsy with cataplexy or excessive daytime sleepiness (EDS). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

## SOFOSBUVIR/VELPATASVIR

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### Products Affected

- Sofosbuvir/velpatasvir

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | None   |
| <b>Required Medical Information</b> | Criteria will be applied consistent with current AASLD-IDSA guidance.                                      |
| <b>Age Restrictions</b>             | None   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist. |
| <b>Coverage Duration</b>            | Criteria will be applied consistent with current AASLD-IDSA guidance.                                      |
| <b>Other Criteria</b>               | None   |

# SOMAVERT

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## Products Affected

- Somavert

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of acromegaly and has had a failure of, or is unable to tolerate, a treatment regimen that includes octreotide, and the member is not a candidate for or has had an inadequate response to surgery and/or radiation. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an endocrinologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# SORAFENIB

## Products Affected

- Sorafenib

- Sorafenib Tosylate TABS

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Advanced Renal Cell Carcinoma (ARCC): The member must have a documented diagnosis of ARCC. Hepatocellular Carcinoma (HCC): The member must have a documented diagnosis of unresectable HCC. Thyroid Carcinoma (TC): The member must have a documented diagnosis of locally recurrent or metastatic, progressive, differentiated TC refractory to radioactive iodine treatment. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a nephrologist, oncologist, or urologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# SPRYCEL

## Products Affected

- Dasatinib

- Sprycel

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Chronic Myeloid Leukemia (CML): 1) The member must have a documented diagnosis of Philadelphia chromosome-positive (Ph+) CML in chronic phase or 2) The member has a documented diagnosis of chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML and documented resistance or intolerance to prior therapy, including imatinib mesylate or 3) newly diagnosed with Ph+ CML in chronic phase.<br>Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL): The member must have a documented diagnosis of Ph+ALL and documented resistance or intolerance to prior therapy. For Pediatric Members: The member must have a documented diagnosis of Ph+CML in chronic phase or the member has Ph+ALL and Sprycel is being used in combination with chemotherapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# STIVARGA

## Products Affected

- Stivarga

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Gastrointestinal Stromal Tumors (GIST): The member must have a documented diagnosis of GIST and documented failure, contraindication, or intolerance to both imatinib mesylate (Gleevec) and Sutent (sunitinib malate). Hepatocellular Carcinoma: The member must have a documented diagnosis of hepatocellular carcinoma and had a documented failure, contraindication, or intolerance to Nexavar (sorafenib). Metastatic Colorectal Cancer (MCC): The member must have a documented diagnosis of MCC and has been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-vascular endothelial growth factor (VEGF) therapy, and, if RAS wild type, an anti-epidermal growth factor receptor (EGFR) therapy. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |



# SUNITINIB

## Products Affected

- Sunitinib Malate

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Advanced Renal Cell Carcinoma (ARCC): The member must have a documented diagnosis of ARCC. Gastrointestinal Stromal Tumor (GIST): The member must have a documented diagnosis of GIST and has a demonstrated disease progression or intolerance with imatinib mesylate. Progressive Neuroendocrine Tumors (pNET): The member must have a documented diagnosis of unresectable, locally advanced, or metastatic pNET located in the pancreas. Recurrent Renal Cell Carcinoma (RCC): The member must have a documented diagnosis of recurrent RCC following nephrectomy |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# TABRECTA

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## Products Affected

- Tabrecta

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) with a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# TADALAFIL

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## Products Affected

- Tadalafil TABS 2.5MG, 5MG

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | Tadalafil is excluded from coverage for the treatment of Erectile Dysfunction.  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis or signs and symptoms of Benign Prostatic Hyperplasia (BPH) and has had a documented failure, adverse reaction, or contraindication to a 30-day trial of at least two of the following medications: alfuzosin, doxazosin, dutasteride, dutasteride-tamsulosin, finasteride, tamsulosin, or terazosin. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# TAFINLAR

## Products Affected

- Tafinlar

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | Tafinlar is not indicated for the treatment of patients with wild-type BRAF mutations.   |
| <b>Required Medical Information</b> | Single Agent: The member must have a documented diagnosis of unresectable or metastatic melanoma with a BRAF V600E mutation. In Combination with Mekinist: The member must have a documented diagnosis of one of the following: 1) Unresectable or metastatic melanoma with a BRAF V600E or V600K mutation. 2) Melanoma with a BRAF V600E or V600K mutation and involvement of lymph node(s) following complete resection. 3) Metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation. 4) Locally advanced or metastatic anaplastic thyroid cancer (ATC) with a BRAF V600E mutation with no satisfactory locoregional treatment options. 5) Unresectable or metastatic solid tumors with BRAF V600E mutation and has progressed following prior treatment. 6) low grade glioma with BRAF V600E mutation that requires systemic therapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# TAGRISSEO

## Products Affected

- Tagrisso

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations OR 2) metastatic EGFR T790M mutation-positive NSCLC whose disease has progressed on or after EGFR tyrosine kinase inhibitor (TKI) therapy (including but not limited to: Gilotrif, Iressa, Tarceva) or 3) NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations and Tagrisso is being used as a) adjuvant therapy after tumor resection b) first-line treatment in combination with pemetrexed and platinum-based chemotherapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# TALZENNA

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## Products Affected

- Talzenna

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) deleterious or suspected deleterious germline BRCA-mutated, HER2-negative locally advanced or metastatic breast cancer or 2) HRR gene-mutated metastatic castration-resistant prostate cancer (mCRPC) and is being used in combination with enzalutamide. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# TASIGNA

## Products Affected

- Nilotinib Hydrochloride

- Tassigna

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Philadelphia chromosome-positive chronic myeloid leukemia in chronic phase (Ph+ CML-CP): The member must have a documented diagnosis of Ph+ CML in chronic phase and the requested drug is being used as initial therapy. Resistant or Intolerant Ph+ CML-CP and CML-AP: The member must have a documented diagnosis of Ph+ CML in chronic phase or accelerated phase and documented resistance or intolerance to prior therapy, including imatinib mesylate (Gleevec). Pediatric Patients: The member must have a documented diagnosis of 1) Ph+ CML in chronic phase and is newly diagnosed or 2) Ph+ CML in chronic or accelerated phase and has a resistance or intolerance to prior tyrosine-kinase inhibitor (TKI) therapy. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# TASIMELTEON

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## Products Affected

- Tasimelteon

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | Coverage will not be authorized for the diagnosis of insomnia.   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of Smith-Magenis Syndrome (SMS) and be experiencing nighttime sleep disturbances or the member must be completely blind and have a documented diagnosis of non-24-hour sleep-wake disorder (non-24). |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a neurologist or sleep specialist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |



# TAVNEOS

## Products Affected

- Tavneos

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | 1) Diagnosis of one of the following types of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis: a) Granulomatosis with polyangiitis (GPA) OR b) Microscopic polyangiitis (MPA) and 2) Patient is receiving concurrent immunosuppressant therapy with one of the following: a) cyclophosphamide OR b) rituximab and 3) one of the following: a) Patient is concurrently on glucocorticoids (e.g., prednisone) OR b) History of contraindication or intolerance to glucocorticoids (e.g., prednisone). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# TAZVERIK

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## Products Affected

- Tazverik

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have one of the following requirements: 1) The member must have a documented diagnosis of metastatic or locally advanced epithelioid sarcoma not eligible for complete resection. 2) The member must have a documented diagnosis of relapsed or refractory follicular lymphoma whose tumors are positive for an EZH2 mutation and has received at least two prior systemic therapies. 3) The member must have a documented diagnosis of relapsed or refractory follicular lymphoma who have no satisfactory alternative treatment options. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# TEPMETKO

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## Products Affected

- Tepmetko

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) harboring mesenchymal-epithelial transition (MET) exon 14 skipping alterations. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# TERIPARATIDE

## Products Affected

- Bonsity

- Teriparatide

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | Coverage for teriparatide will not be authorized when cumulative use of it and/or other parathyroid hormone analogs is greater than 2 years.  |
| <b>Required Medical Information</b> | The requesting physician must provide documentation that the member is 1) a postmenopausal woman with osteoporosis 2) a man with primary or hypogonadal osteoporosis or 3) man or woman with osteoporosis associated with sustained systemic glucocorticoid therapy and 4) at high risk for fracture and has a T score less than or equal to -2.0 as evidenced via bone density scan or the requesting physician has documented that the member has had one or more osteoporotic fractures. For either condition previously listed, the member must have had an inadequate response to, or is unable to tolerate therapy with at least one of the traditional osteoporosis treatments (including but not limited to: alendronate (Fosamax), calcitonin (Miacalcin), denosumab (Prolia), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel) or zoledronic acid (Reclast)). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | All uses (initial): 24 months. All uses (reauth): 12 months.  |
| <b>Other Criteria</b>               | N/A   |

# TETRABENAZINE

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## Products Affected

- Tetrabenazine

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of chorea associated with Huntington's Disease. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a neurologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# TIBSOVO

## Products Affected

- Tibsovo

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | <p>Relapsed or Refractory Acute Myeloid Leukemia (AML): The member must have a documented diagnosis of relapsed or refractory AML with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. Acute Myeloid Leukemia (AML): The member must have a documented diagnosis of AML with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation, Tibsovo is being used as first-line therapy, and the member meets one of the following: 1) is 75 years of age or older or 2) has comorbidities that make them ineligible for intensive induction chemotherapy.</p> <p>Cholangiocarcinoma: The member must have a documented diagnosis of locally advanced or metastatic cholangiocarcinoma who have been previously treated. Relapsed or refractory Myelodysplastic Syndromes (MDS): The member must have a documented diagnosis of MDS</p> |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# TRANSMUCOSAL IMMEDIATE-RELEASE FENTANYL (TIRF)

## Products Affected

- Fentanyl Citrate Oral Transmucosal

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | The Transmucosal Immediate-Release Fentanyl (TIRF) products will not be covered for any non-cancer pain indication.  |
| <b>Required Medical Information</b> | The Transmucosal Immediate-Release Fentanyl (TIRF) products will be covered for the management of breakthrough pain in adult cancer patients who are already receiving and who are tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain. (applies to Fentanyl lozenges only) Approvable for pediatric patients 16 years of age and older.   |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist or a pain management specialist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of, but not limited to, morphine oral 60 mg daily or more, fentanyl transdermal 25 mcg/hour or more, oxycodone oral 30 mg daily or more, hydromorphone oral 8 mg daily or more, or an equianalgesic dose of another opioid daily for a week or longer. Patients must remain on around-the-clock opioids when taking fentanyl transmucosal. |

# TRUQAP

## Products Affected

- Truqap

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Diagnosis of breast cancer. Disease is one of the following: locally advanced or metastatic. Will be taken in combination with fulvestrant. Disease is hormone receptor (HR)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Patient has one or more PIK3CA/AKT1/PTEN-alterations. One of the following: A) Following progression on at least one endocrine-based regimen in the metastatic setting (e.g., anastrozole, letrozole, exemestane, tamoxifen, etc.) OR B) Recurrence on or within 12 months of completing adjuvant therapy (e.g., chemotherapy). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |



# TRUSELTIQ

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## Products Affected

- Truseltiq

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# TUKYSA

## Products Affected

- Tukysa

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) advanced unresectable or metastatic HER2-positive breast cancer, including patients with brain metastases, who have received one or more prior anti-HER2-based regimens in the metastatic setting and be taking in combination with trastuzumab and capecitabine or 2) RAS wild-type HER-2 positive unresectable or metastatic colorectal cancer that has progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy and be taking in combination trastuzumab. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# TURALIO

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## Products Affected

- Turalio

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and the condition is not amenable to improvement with surgery. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# UBRELVY

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## Products Affected

- Ubrelyvy

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of migraines and has had an inadequate response, intolerance, or contraindication to at least one triptan medication. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# USTEKINUMAB

## Products Affected

- Steqeyma INJ 45MG/0.5ML, 90MG/ML
- Yesintek INJ 45MG/0.5ML, 90MG/ML

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | <p>Crohn's Disease (CD): The member must have a documented diagnosis CD and a trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroids (e.g., prednisone, methylprednisolone, or methotrexate).</p> <p>Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe plaque psoriasis and has failed to respond to or has been unable to tolerate treatment with one of the following: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, or Coal tar.</p> <p>Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis.</p> <p>Ulcerative Colitis (UC): The member must have a documented diagnosis of UC.</p> |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with a dermatologist, gastroenterologist or rheumatologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# VALTOCO

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## Products Affected

- Valtoco 10 Mg Dose
- Valtoco 15 Mg Dose
- Valtoco 20 Mg Dose
- Valtoco 5 Mg Dose

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of a seizure disorder requiring acute treatment. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a neurologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# VANFLYTA

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## Products Affected

- Vanflyta

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of newly diagnosed Acute Myeloid Leukemia (AML) that is FLT3 internal tandem duplication (ITD) positive as detected by an FDA approved test. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist or a hematologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# VENCLEXTA

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## Products Affected

- Venclexta

- Venclexta Starting Pack

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Acute Myeloid Leukemia (AML): The member must have a documented diagnosis of AML and the requested drug is being used as first-line therapy in combination with azacitidine, decitabine, or low-dose cytarabine and the member meets one of the following: 1) is 75 years of age or older or 2) has comorbidities that make them ineligible for intensive induction chemotherapy. Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL): The member must have a documented diagnosis of CLL or SLL. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |



# VEOZAH

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## Products Affected

- Veozah

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.                                  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Diagnosis of moderate to severe vasomotor symptoms due to menopause. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# VERZENIO

## Products Affected

- Verzenio

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | For Monotherapy: The member must have a documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative metastatic breast cancer with disease progression following endocrine therapy and prior chemotherapy. For Combination Therapy with Faslodex (fulvestrant): The member must have a documented diagnosis of HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy. For Combination Therapy with an Aromatase Inhibitor as initial endocrine-based therapy: The member must have a documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer. Combination with Endocrine Therapy (tamoxifen or an aromatase inhibitor): The member must have a documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node-positive, early breast cancer at high risk of recurrence. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# VIGAFYDE

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## Products Affected

- Vigafyde

| <b>PA Criteria</b>                  | <b>Criteria Details</b>               |
|-------------------------------------|---------------------------------------|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A                                   |
| <b>Exclusion Criteria</b>           | N/A                                   |
| <b>Required Medical Information</b> | Diagnosis of infantile spasms.        |
| <b>Age Restrictions</b>             | Patient is 1 month to 2 years of age. |
| <b>Prescriber Restrictions</b>      | N/A                                   |
| <b>Coverage Duration</b>            | 2 years                               |
| <b>Other Criteria</b>               | N/A                                   |

# VITRAKVI

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## Products Affected

- Vitrakvi

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of metastatic or surgically unresectable neurotrophic receptor tyrosine kinase (NTRK) gene fusion-positive solid tumors with no known acquired resistance mutation and with no satisfactory alternative treatments or the member has progressed following treatment. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# VIZIMPRO

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## Products Affected

- Vizimpro

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) in tumors that have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# VONJO

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## Products Affected

- Vonjo

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis with a platelet count less than $50 \times 10^9/L$ . |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# VORANIGO

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## Products Affected

- Voranigo

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Diagnosis of astrocytoma or oligodendroglioma. Presence of a susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation. History of one of the following: a) Biopsy, b) Sub-total resection, or c) Gross total resection. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | Approve for continuation of therapy  |

# VORICONAZOLE FOR IV INJECTION

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## Products Affected

- Voriconazole INJ

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) infection caused by Aspergillus or Candida, including candidemia or other serious invasive candidiasis infection, invasive aspergillosis, CNS infection (i.e. meningitis), cardiovascular system infection (i.e. endocarditis, myocarditis, pericarditis, infected pacemaker, implantable cardiac defibrillator, or ventricular assist devices), esophageal candidiasis, invasive pulmonary aspergillosis and other Aspergillus respiratory infection (i.e. pneumonia, tracheobronchitis, sinusitis, aspergilloma), intrabdominal infections, bone and joint infection, fungal skin and skin structure infection or 2) serious fungal infection caused by Scedosporium apiospermum or Fusarium and intolerant of, or refractory to, other therapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |



# VOSEVI

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## Products Affected

- Vosevi

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Criteria will be applied consistent with current AASLD-IDSA guidance.                                      |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist. |
| <b>Coverage Duration</b>            | Criteria will be applied consistent with current AASLD-IDSA guidance.                                      |
| <b>Other Criteria</b>               | N/A  |

# VOTRIENT

## Products Affected

- Pazopanib Hydrochloride

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Advanced Renal Cell Carcinoma (RCC): The member must have a documented diagnosis of advanced RCC. Advanced Soft Tissue Sarcoma (STS): The member must have a documented diagnosis of advanced STS and has received prior chemotherapy, including anthracycline treatment, or was unsuited for such therapy. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# VOWST

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## Products Affected

- Vowst

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All Medically-accepted Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Diagnosis of recurrent clostridioides difficile infection (CDI) and the patient has completed one of the following antibiotic therapies 2-4 days prior to initiating Vowst: oral vancomycin or Dificid (fidaxomicin) |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with a gastroenterologist or infectious disease specialist.   |
| <b>Coverage Duration</b>            | 14 days  |
| <b>Other Criteria</b>               | N/A  |

# WELIREG

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## Products Affected

- Welireg

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) von Hippel-Lindau disease and require therapy for associated renal cell carcinoma, CNS hemangioblastomas, or pancreatic neuroendocrine tumors, not requiring immediate surgery or 2) Advanced Renal Cell Carcinoma (RCC) following a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# XALKORI

## Products Affected

- Xalkori

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive or the member has documented ROS1-positive tumors, 2) relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive, or 3) unresectable, recurrent, or refractory inflammatory myofibroblastic tumor (IMT) that is ALK-positive. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# XDEMZY

## Products Affected

- Xdemzy

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of Demodex blepharitis.                             |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The medication must be prescribed by or in consultation with an ophthalmologist or optometrist. |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# XELJANZ

## Products Affected

- Xeljanz

- Xeljanz Xr

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Ankylosing spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Rheumatoid Arthritis (RA): The member must 1) have a documented diagnosis of RA and 2) has a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine and 3) has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Enbrel, Humira). Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must 1) have a documented diagnosis of PJIA and 2) has a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine and 3) has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Enbrel, Humira). Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Enbrel, Humira). Ulcerative Colitis (UC): The member must 1) have a documented diagnosis of UC and 2) has a trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate [e.g., mesalamine (Asacol, Pentasa, Rowasa), Dipentum (olsalazine), sulfasalazine], azathioprine, or corticosteroids (e.g., prednisone, methylprednisolone) and 3) has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Humira). |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with a gastroenterologist or rheumatologist.  |
| <b>Coverage Duration</b>            | 2 years  |

|                       |     |
|-----------------------|-----|
| <b>Other Criteria</b> | N/A |
|-----------------------|-----|



# XERMELO

## Products Affected

- Xermelo

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of carcinoid syndrome diarrhea that is inadequately controlled by somatostatin analog (SSA) therapy alone and Xermelo is being used in combination with an SSA (e.g. Sandostatin LAR). |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a gastroenterologist, hematologist, or oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# XGEVA

## Products Affected

- Xgeva

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Coverage for Xgeva (denosumab) will be authorized if one of the following is met: 1) for prevention of skeletal-related events in patients with multiple myeloma or with bone metastases from solid tumors 2) the member is being treated for unresectable giant cell tumor of bone (GCTB) or surgical resection of GCTB is likely to result in severe morbidity 3) for the treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# XIFAXAN 550 MG

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## Products Affected

- Xifaxan TABS 550MG

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Hepatic Encephalopathy: The member must have a documented diagnosis of hepatic encephalopathy and has had an inadequate response or a contraindication to lactulose. Irritable Bowel Syndrome with Diarrhea (IBS-D): The member must have a documented diagnosis of IBS-D. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | N/A  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# XOLAIR

## Products Affected

- Xolair

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | <p>Asthma: The member must 1) have a documented diagnosis of moderate-to-severe persistent asthma 2) has had a failure of a treatment regimen that included two or more of the following medications: inhaled corticosteroids, oral corticosteroids, leukotriene modifiers and inhaled long-acting bronchodilators, or is unable to tolerate these medications. 3) shows a definitive sensitivity on allergy testing to one or more perennial allergens and 4) The member has a pre-treatment serum IgE level equal to or greater than 30 IU/mL and less than or equal to 1,300 IU/mL. Chronic Spontaneous Urticaria (CSU): 1) The member has a documented diagnosis of CSU and 2) the physician has documented that the member remains symptomatic despite H1 antihistamine treatment. Nasal polyps: The member must have a documented diagnosis of nasal polyps with inadequate response to nasal corticosteroids. IgE-mediated food allergy: For the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods.</p> |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an allergist, dermatologist, immunologist, otolaryngologist or pulmonologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# XOSPATA

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## Products Affected

- Xospata

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of relapsed or refractory acute myeloid leukemia (AML) with a FLT3 mutation. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# XPOVIO

## Products Affected

- Xpovio

- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Twice Weekly

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | In combination with dexamethasone: The member must meet ALL of the following criteria: 1) Documented diagnosis of relapsed or refractory multiple myeloma. 2) Has received at least four prior therapies. 3) The member's disease is refractory to at least two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody. In combination with (Velcade) bortezomib and dexamethasone: The member must have a documented diagnosis of multiple myeloma and has received at least one prior therapy. Relapsed or Refractory Diffuse Large B-cell Lymphoma (DLBCL): The member must have a documented diagnosis of DLBCL, not otherwise specified, including DLBCL arising from follicular lymphoma, and has received at least 2 lines of systemic therapy. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# XTANDI

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## Products Affected

- Xtandi

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of 1) castration-resistant prostate cancer or 2) metastatic castration-sensitive prostate cancer or 3) non-metastatic castration-sensitive prostate cancer with biochemical recurrence at high risk for metastasis. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist or urologist.   |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

# ZEJULA

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## Products Affected

- Zejula

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | The member must meet one of the two following requirements: 1) The member must have a documented diagnosis of advanced or recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and is experiencing complete or partial response to platinum-based chemotherapy 2) The member must have a documented diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer with a deleterious or suspected deleterious germline BRCA mutation and who are in a complete or partial response to platinum-based chemotherapy. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |



# ZELBORAF

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## Products Affected

- Zelboraf

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | Zelboraf is not indicated for treatment of patients with wild-type BRAF melanoma.  |
| <b>Required Medical Information</b> | Erdheim-Chester Disease (ECD): The member must have a documented diagnosis of ECD with a BRAF V600 mutation. Unresectable or Metastatic Melanoma: The member must have a documented diagnosis of unresectable or metastatic melanoma that is BRAF V600E mutation-positive. |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.   |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# ZOLINZA

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## Products Affected

- Zolinza

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of cutaneous T-cell lymphoma with progressive, persistent or recurrent disease and documented current or prior treatment or treatment failure with at least two systemic chemotherapeutic agents for cutaneous T-cell lymphoma. |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

## ZTALMY

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### Products Affected

- Ztalmy

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have 1) a diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) and 2) a trial and failure, contraindication, or intolerance to two formulary anticonvulsants (e.g., valproic acid, levetiracetam, lamotrigine). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | Prescribed by or in consultation with a neurologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

## ZURZUVAE

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### Products Affected

- Zurzuvae

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All Medically-accepted Indications.                             |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | Postpartum Depression (PPD): Diagnosis of postpartum Depression |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | N/A   |
| <b>Coverage Duration</b>            | 14 days   |
| <b>Other Criteria</b>               | N/A   |

# ZYDELIG

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## Products Affected

- Zydelig

| <b>PA Criteria</b>                  | <b>Criteria Details</b>  |
|-------------------------------------|--|
| <b>Indications</b>                  | All FDA-approved Indications.  |
| <b>Off-Label Uses</b>               | N/A  |
| <b>Exclusion Criteria</b>           | N/A  |
| <b>Required Medical Information</b> | Chronic Lymphocytic Leukemia (CLL): The member must have a documented diagnosis of relapsed CLL and Zydelig is being used in combination with Rituxan (rituximab). |
| <b>Age Restrictions</b>             | N/A  |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be a hematologist or oncologist.  |
| <b>Coverage Duration</b>            | 2 years  |
| <b>Other Criteria</b>               | N/A  |

# ZYKADIA

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## Products Affected

- Zykadia TABS

| <b>PA Criteria</b>                  | <b>Criteria Details</b>   |
|-------------------------------------|---|
| <b>Indications</b>                  | All FDA-approved Indications.   |
| <b>Off-Label Uses</b>               | N/A   |
| <b>Exclusion Criteria</b>           | N/A   |
| <b>Required Medical Information</b> | The member must have a documented diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC). |
| <b>Age Restrictions</b>             | N/A   |
| <b>Prescriber Restrictions</b>      | The prescribing physician must be an oncologist.  |
| <b>Coverage Duration</b>            | 2 years   |
| <b>Other Criteria</b>               | N/A   |

## PART B VERSUS PART D

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### Products Affected

- Acetylcysteine SOLN
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Aminosyn II INJ 107.6MEQ/L; 1490MG/100ML; 1527MG/100ML; 1050MG/100ML; 1107MG/100ML; 750MG/100ML; 450MG/100ML; 990MG/100ML; 1500MG/100ML; 1575MG/100ML; 258MG/100ML; 405MG/100ML; 447MG/100ML; 1083MG/100ML; 795MG/100ML; 50MEQ/L; 600MG/100ML; 300MG/100ML; 750MG/100ML
- Aminosyn-pf 7% INJ 32.5MEQ/L; 490MG/100ML; 861MG/100ML; 370MG/100ML; 576MG/100ML; 270MG/100ML; 220MG/100ML; 534MG/100ML; 831MG/100ML; 475MG/100ML; 125MG/100ML; 300MG/100ML; 570MG/100ML; 347MG/100ML; 50MG/100ML; 360MG/100ML; 125MG/100ML; 44MG/100ML; 452MG/100ML
- Aprepitant
- Arformoterol Tartrate
- Azathioprine TABS
- Bivigam INJ 10%, 5GM/50ML
- Budesonide SUSP
- Clinimix 6/5
- Clinimix 8/10
- Clinimix E 8/10
- Cromolyn Sodium NEBU
- Cuvitru
- Cyclophosphamide CAPS
- Cyclophosphamide TABS
- Cyclosporine CAPS
- Cyclosporine Modified
- Dronabinol
- Engerix-b
- Envarsus Xr
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Flebogamma Dif INJ 10GM/100ML, 10GM/200ML, 2.5GM/50ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Formoterol Fumarate NEBU
- Gammagard Liquid INJ 10GM/100ML, 2.5GM/25ML, 20GM/200ML, 30GM/300ML, 5GM/50ML
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Heplisav-b
- Hizentra
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU
- Levalbuterol Hydrochloride NEBU 0.63MG/3ML
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Nutrilipid
- Octagam INJ 10GM/100ML, 10GM/200ML, 1GM/20ML, 2.5GM/50ML, 20GM/200ML, 2GM/20ML, 30GM/300ML, 5GM/100ML, 5GM/50ML
- Ondansetron Hcl SOLN
- Ondansetron Hcl TABS 24MG
- Ondansetron Hydrochloride TABS

- Ondansetron Odt TBDP 4MG, 8MG
- Pentamidine Isethionate  
INHALATION SOLR
- Plenammine INJ 147.4MEQ/L;  
2.17GM/100ML; 1.47GM/100ML;  
434MG/100ML; 749MG/100ML;  
1.04GM/100ML; 894MG/100ML;  
749MG/100ML; 1.04GM/100ML;  
1.18GM/100ML; 749MG/100ML;  
1.04GM/100ML; 894MG/100ML;  
592MG/100ML; 749MG/100ML;  
250MG/100ML; 39MG/100ML;  
960MG/100ML
- Prehevbrio
- Premasol INJ 52MEQ/L;  
1760MG/100ML; 880MG/100ML;  
34MEQ/L; 1760MG/100ML;  
372MG/100ML; 406MG/100ML;  
526MG/100ML; 492MG/100ML;  
492MG/100ML; 526MG/100ML;  
356MG/100ML; 356MG/100ML;  
390MG/100ML; 34MG/100ML;  
152MG/100ML
- Privigen
- Prograf PACK
- Prosol
- Pulmozyme SOLN 2.5MG/2.5ML
- Recombivax Hb
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Travasol INJ 52MEQ/L;  
1760MG/100ML; 880MG/100ML;  
34MEQ/L; 1760MG/100ML;  
372MG/100ML; 406MG/100ML;  
526MG/100ML; 492MG/100ML;  
492MG/100ML; 526MG/100ML;  
356MG/100ML; 500MG/100ML;  
356MG/100ML; 390MG/100ML;  
34MG/100ML; 152MG/100ML
- Trophamine INJ 0.54GM/100ML;  
1.2GM/100ML; 0.32GM/100ML; 0; 0;  
0.5GM/100ML; 0.36GM/100ML;  
0.48GM/100ML; 0.82GM/100ML;  
1.4GM/100ML; 1.2GM/100ML;  
0.34GM/100ML; 0.48GM/100ML;  
0.68GM/100ML; 0.38GM/100ML;  
5MEQ/L; 0.025GM/100ML;  
0.42GM/100ML; 0.2GM/100ML;  
0.24GM/100ML; 0.78GM/100ML

## Details

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



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