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- KALYDECO 150MG TAB
- KALYDECO 50MG GRANULES

- KALYDECO 25MG GRANULES
- KALYDECO 75MG GRANULES

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

## Products Affected

- KEVZARA 150MG/1.14ML AUTO-INJECTOR
- KEVZARA 200MG/1.14ML AUTO-INJECTOR

- KEVZARA 150MG/1.14ML SYRINGE
- KEVZARA 200MG/1.14ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis: Intolerance to, or failure of therapy with, 2 of the following: a) Humira, b) Enbrel, c) Rinvoq OR d) Xeljanz
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance or contraindication to therapy with both of the following: a) Verzenio AND b) Ibrance.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– KORLYM 300MG TAB

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

## Products Affected

– KOSELUGO 10MG CAP (New Starts Only)

– KOSELUGO 25MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Chart notes documentation is provided that indicates inoperable and symptomatic disease
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- KUVAN 100MG POWDER FOR ORAL SOLN
- *sapropterin 100mg powder for oral soln*
- *sapropterin 500mg powder for oral soln*

- KUVAN 500MG POWDER FOR ORAL SOLN
- *sapropterin 100mg tab*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuing therapy: member must have shown at least a 20% drop in Phenylalanine levels after 2 months of sapropterin (Kuvan) treatment.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a medical geneticist or metabolic physician.
Coverage Duration	Initial approval of 3 months. Continuing therapy approved for duration of contract year.
Other Criteria	

## Products Affected

– LAMPIT 30MG TAB

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

## Products Affected

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

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

**Products Affected**

— *ambrisentan 10mg tab*

— *ambrisentan 5mg tab*

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

## Products Affected

— *lidocaine 5% patch*

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

**Products Affected**

– LOKELMA 10GM POWDER FOR ORAL SUSP

– LOKELMA 5GM POWDER FOR ORAL SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has baseline persistent potassium level greater than 5.0 mmol/L.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist, cardiologist, hematologist or endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



**Products Affected**

— LONSURF 6.14-15MG TAB (New Starts Only)

— LONSURF 8.19-20MG TAB (New Starts Only)

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

**Products Affected**

— LORBRENA 100MG TAB (New Starts Only)

— LORBRENA 25MG TAB (New Starts Only)

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

## Products Affected

– LUMAKRAS 120MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of KRAS G12C mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– LUPKYNIS 7.9MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuation therapy: Documentation is provided of disease improvement.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatologist or nephrologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Will not be used in combination with belimumab (Benlysta)

**Products Affected**

- LUPRON 11.25MG SYRINGE (New Starts Only)
- LUPRON 3.75MG SYRINGE (New Starts Only)
- LUPRON 7.5MG SYRINGE (New Starts Only)
- LUPRON 22.5MG SYRINGE (New Starts Only)
- LUPRON 45MG SYRINGE (New Starts Only)

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

## Products Affected

– LYNPARZA 100MG TAB (New Starts Only)

– LYNPARZA 150MG TAB (New Starts Only)

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

## Products Affected

— MAVYRET 100-40MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer is provided 3) Documentation is provided that member does or does not have cirrhosis 4) Previous Hepatitis C Treatment(s) is provided.
Age Restrictions	Member must be 12 years of age or older, or weigh at least 45kg.
Prescriber Restriction	Prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease or transplant specialist.
Coverage Duration	Coverage duration of 8 to 16 weeks. Applied consistent with current AASLD-IDSA guidance.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

## Products Affected

— *megestrol acetate 125mg/ml susp*

— *megestrol acetate 40mg/ml susp*

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



## Products Affected

— *megestrol acetate 20mg tab (New Starts Only)*

— *megestrol acetate 40mg tab (New Starts Only)*

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

## Products Affected

— MEKINIST 0.5MG TAB (New Starts Only)

— MEKINIST 2MG TAB (New Starts Only)

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

## Products Affected

– MEKTOVI 15MG TAB (New Starts Only)

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

**Products Affected**

— MOVANTIK 12.5MG TAB

— MOVANTIK 25MG TAB

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

## Products Affected

- ABELCET 5MG/ML INJ
- *acetylcysteine 200mg/ml inh soln*
- *albuterol 0.21mg/ml inh soln*
- *albuterol 0.83mg/ml inh soln*
- AMBISOME 50MG INJ
- AMPHOTERICIN B 50MG INJ
- *aprepitant 125mg/aprepitant 80mg pack*
- *aprepitant 80mg cap*
- ASTAGRAF 0.5MG ER CAP
- ASTAGRAF 5MG ER CAP
- AZASAN 75MG TAB
- BROVANA 15MCG/2ML INH SOLN
- *budesonide 0.25mg/ml inh susp*
- CLINIMIX 4.25/10 INJ
- CLINIMIX 5/15 INJ
- CLINIMIX E 2.75/5 INJ
- CLINIMIX E 4.25/5 INJ
- CLINIMIX E 5/20 INJ
- CYCLOPHOSPHAMIDE 25MG CAP
- CYCLOPHOSPHAMIDE 50MG CAP
- *cyclosporine 100mg cap*
- *cyclosporine modified 100mg cap*
- *cyclosporine modified 25mg cap*
- DIPHTHERIA/TETANUS TOXOID INJ
- ENGERIX-B 20MCG/ML SYRINGE
- ENVARUSUS 1MG ER TAB
- *everolimus 0.25mg tab*
- *everolimus 0.75mg tab*
- *gengraf 100mg cap*
- *acetylcysteine 100mg/ml inh soln*
- *acyclovir 50mg/ml inj*
- *albuterol 0.417mg/ml inh soln*
- *albuterol 5mg/ml inh soln*
- AMINOSYN-PF 7% INJ
- *aprepitant 125mg cap*
- *aprepitant 40mg cap*
- *arformoterol 15mcg/2ml inh soln*
- ASTAGRAF 1MG ER CAP
- AZASAN 100MG TAB
- *azathioprine 50mg tab*
- *budesonide 0.125mg/ml inh susp*
- *budesonide 0.5mg/ml inh susp*
- CLINIMIX 4.25/5 INJ
- CLINIMIX 5/20 INJ
- CLINIMIX E 4.25/10 INJ
- CLINIMIX E 5/15 INJ
- *clinsol 15% inj*
- CYCLOPHOSPHAMIDE 25MG TAB
- CYCLOPHOSPHAMIDE 50MG TAB
- *cyclosporine 25mg cap*
- *cyclosporine modified 100mg/ml oral soln*
- *cyclosporine modified 50mg cap*
- ENGERIX-B 10MCG/0.5ML SYRINGE
- ENVARUSUS 0.75MG ER TAB
- ENVARUSUS 4MG ER TAB
- *everolimus 0.5mg tab*
- *formoterol fumarate 20mcg/2ml inh soln*
- *gengraf 100mg/ml oral soln*

- *gengraf 25mg cap*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 0.0342 MEQ/ML INJ
- *granisetron 1mg tab*
- IMOVAX 2.5UNIT/ML INJ
- INTRALIPID 30GM/100ML INJ
- *ipratropium/albuterol 0.5-2.5mg/3ml inh soln*
- *levalbuterol 0.21mg/ml inh soln*
- *levalbuterol 2.5mg/ml inh soln*
- *methylprednisolone 16mg tab*
- *methylprednisolone 4mg tab*
- *mycophenolate mofetil 200mg/ml susp*
- *mycophenolate mofetil 500mg tab*
- *mycophenolic acid 360mg dr tab*
- NUTRILIPID 20GM/100ML INJ
- ONDANSETRON 24MG TAB
- *ondansetron 4mg tab*
- *ondansetron 8mg tab*
- *plenamine 15% inj*
- *prednisolone 15mg odt*
- *prednisolone 2mg/ml oral soln*
- PREDNISOLONE 3MG/ML ORAL SOLN
- *prednisone 10mg tab*
- PREDNISONONE 1MG/ML ORAL SOLN
- *prednisone 20mg tab*
- *prednisone 5mg tab*
- PREMASOL 10% INJ
- PROGRAF 0.2MG GRANULES FOR ORAL SUSP
- PROSOL 20% INJ
- RABAVERT 2.5UNIT/ML INJ
- RECOMBIVAX 10MCG/ML SYRINGE
- *glucose 100mg/ml inj*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 0.0769 MEQ/ML INJ
- HUMULIN R 500UNIT/ML INJ
- INTRALIPID 20GM/100ML INJ
- *ipratropium bromide 0.2mg/ml inh soln*
- *levalbuterol 0.103mg/ml inh soln*
- *levalbuterol 0.417mg/ml inh soln*
- MEDROL 2MG TAB
- *methylprednisolone 32mg tab*
- *methylprednisolone 8mg tab*
- *mycophenolate mofetil 250mg cap*
- *mycophenolic acid 180mg dr tab*
- NOVOLOG 100UNIT/ML INJ
- *ondansetron 0.8mg/ml oral soln*
- *ondansetron 4mg odt*
- *ondansetron 8mg odt*
- *pentamidine isethionate 50mg/ml inh soln*
- *prednisolone 10mg odt*
- *prednisolone 1mg/ml oral soln*
- *prednisolone 30mg odt*
- *prednisolone 4mg/ml oral soln*
- *prednisone 1mg tab*
- *prednisone 2.5mg tab*
- *prednisone 50mg tab*
- PREDNISONONE 5MG/ML ORAL SOLN
- PROCALAMINE 3% INJ
- PROGRAF 1MG GRANULES FOR ORAL SUSP
- PULMOZYME 1MG/ML INH SOLN
- RECOMBIVAX 10MCG/ML INJ
- RECOMBIVAX 40MCG/ML INJ

- RECOMBIVAX 5MCG/0.5ML SYRINGE
- RETACRIT 20000UNIT/2ML INJ
- RETACRIT 2000UNIT/ML INJ
- RETACRIT 40000UNIT/ML INJ
- SANDIMMUNE 100MG/ML ORAL SOLN
- *sirolimus 1mg tab*
- *sirolimus 2mg tab*
- *tacrolimus 1mg cap*
- TDVAX 4-4UNIT/ML INJ
- TPN ELECTROLYTES INJ
- TROPHAMINE 10% INJ
- ZORTRESS 1MG TAB

- RETACRIT 10000UNIT/ML INJ
- RETACRIT 20000UNIT/ML INJ
- RETACRIT 3000UNIT/ML INJ
- RETACRIT 4000UNIT/ML INJ
- *sirolimus 0.5mg tab*
- *sirolimus 1mg/ml oral soln*
- *tacrolimus 0.5mg cap*
- *tacrolimus 5mg cap*
- TENIVAC 4-10UNIT/ML SYRINGE
- TRAVASOL 10% INJ
- VARUBI 90MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	
Other Criteria	

## Products Affected

- NATPARA 100MCG CARTRIDGE
- NATPARA 50MCG CARTRIDGE

- NATPARA 25MCG CARTRIDGE
- NATPARA 75MCG CARTRIDGE

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



## Products Affected

—NERLYNX 40MG TAB (New Starts Only)

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

## Products Affected

— NEXAVAR 200MG TAB (New Starts Only)

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

## Products Affected

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

- NINLARO 3MG CAP (New Starts Only)

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

**Products Affected**

- *droxidopa 100mg cap*
- *droxidopa 300mg cap*

- *droxidopa 200mg cap*

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

**Products Affected**

— NOURIANZ 20MG TAB

— NOURIANZ 40MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has tried and failed one agent from both of the following classes when used in combination with carbidopa/levodopa: 1) COMT inhibitor AND 2) MAO-B inhibitor.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

— NOXAFIL 40MG/ML SUSP

— *posaconazole 100mg dr tab*

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

## Products Affected

– NUBEQA 300MG TAB (New Starts Only)

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

## Products Affected

- NUCALA 100MG INJ
- NUCALA 100MG/ML SYRINGE

- NUCALA 100MG/ML AUTO-INJECTOR

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Asthma diagnosis: A) Peripheral blood eosinophil count is provided and is greater than or equal to 150 cells per microliter. B) History of 1 or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s). For eosinophilic granulomatosis with polyangiitis (EGPA), confirmation of diagnosis required.
Age Restrictions	For Severe Asthma diagnosis: Member must be 6 years of age or older. For eosinophilic granulomatosis with polyangiitis (EGPA) diagnosis: Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with, an allergy specialist, immunologist, pulmonary specialist or rheumatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

— NUEDEXTA 20-10MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: A) Documentation is provided of structural neurological condition as the cause of pseudobulbar affect B) Disease severity demonstrated by a score of 13 or greater on the Center for Neurologic Study Lability Scale (CNS-LS) AND C) Member has tried and failed an SSRI. For continuation requests: A) Documentation is provided of structural neurological condition as the cause of pseudobulbar affect B) Member has demonstrated improvement while on Nuedexta, defined as one of the following: i) a score of less than 13 on the Center for Neurologic Study Lability Scale (CNS-LS) OR ii) an improvement of 7 or more points on the CNS-LS. AND C) Member has tried and failed an SSRI.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– NUPLAZID 10MG TAB (New Starts Only)

– NUPLAZID 34MG CAP (New Starts Only)

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

**Products Affected**

– NURTEC 75MG ODT

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trials of 2 different triptans were ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

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

- *armodafinil 200mg tab*
- *armodafinil 50mg tab*
- *modafinil 200mg tab*

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

## Products Affected

— NUZYRA 150MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for 1 month subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

— OCALIVA 10MG TAB

— OCALIVA 5MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has one of the following: a) inadequate response to a year of therapy with ursodiol OR b) experienced intolerance to ursodiol.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hepatologist or gastroenterologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– ODOMZO 200MG CAP (New Starts Only)

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

## Products Affected

— OFEV 100MG CAP

— OFEV 150MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) For idiopathic pulmonary fibrosis: Diagnosis confirmed by both of the following: A) No known cause of lung fibrosis AND B) One of the following: i) Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) ii) High-resolution computed tomography (HRCT) indicates definite UIP pattern iii) Both HRCT indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP. 2) For systemic sclerosis-associated interstitial lung disease (ILD): A) Diagnosis confirmed with documentation provided of both of the following: i) HRCT scan AND ii) pulmonary function tests B) Member has tried and failed mycophenolate. 3) For chronic fibrosing ILDs with a progressive phenotype: A) Presence of reticular abnormality with traction bronchiectasis with a disease extent of more than 10% on HRCT B) Disease is progressive, defined by one of the following over the past 24 months, despite treatment: i) Forced vital capacity (FVC) decline of 10% or more OR ii) Two of the following: a) FVC decline of 5% or more b) worsening respiratory symptoms c) increasing extent of fibrotic changes on chest imaging C) Progression occurred despite treatment with one of the following: i) azathioprine ii) cyclosporine iii) mycophenolate mofetil iv) tacrolimus v) oral corticosteroids equivalent to 20 mg or more per day of prednisone vi) cyclophosphamide vii) rituximab
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist, pulmonologist, or rheumatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

— OLUMIANT 1MG TAB

— OLUMIANT 2MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis: Intolerance to, or failure of therapy with, 2 of the following: a) Humira, b) Enbrel, c) Rinvoq OR d) Xeljanz
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with, a rheumatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

— ONGENTYS 25MG CAP

— ONGENTYS 50MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has tried and failed one agent from both of the following classes when used in combination with carbidopa/levodopa: 1) COMT inhibitor AND 2) MAO-B inhibitor.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— ONUREG 200MG TAB (New Starts Only)

— ONUREG 300MG TAB (New Starts Only)

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

## Products Affected

– OPSUMIT 10MG TAB

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

## Products Affected

- *fentanyl 0.2mg lozenge*
- *fentanyl 0.6mg lozenge*
- *fentanyl 1.2mg lozenge*

- *fentanyl 0.4mg lozenge*
- *fentanyl 0.8mg lozenge*
- *fentanyl 1.6mg lozenge*

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

## Products Affected

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

- ORENCIA 125MG/ML SYRINGE
- ORENCIA 87.5MG/0.7ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis: Intolerance to, or failure of therapy with, 2 of the following: a) Enbrel, b) Humira, c) Rinvoq OR d) Xeljanz. For polyarticular juvenile idiopathic arthritis: Intolerance to, or failure of therapy with 2 of the following: a) Humira, b) Enbrel OR c) Xeljanz. For Psoriatic Arthritis: Intolerance to, or failure of therapy with, 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Stelara, e) Otezla OR f) Xeljanz.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

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

- ORENITRAM 0.25MG ER TAB
- ORENITRAM 2.5MG ER TAB

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

**Products Affected**

- *nitisinone 10mg cap*
- *nitisinone 5mg cap*
- ORFADIN 4MG/ML SUSP

- *nitisinone 2mg cap*
- ORFADIN 20MG CAP

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



## Products Affected

— ORGOVYX 120MG TAB (New Starts Only)

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

## Products Affected

— ORIAHNN 28 DAY KIT PACK

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

## Products Affected

— ORILISSA 150MG TAB

— ORILISSA 200MG TAB

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

## Products Affected

- ORKAMBI 125-100MG GRANULES
- ORKAMBI 125-200MG TAB

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

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

## Products Affected

— OSPHENA 60MG TAB

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

## Products Affected

— OTEZLA 28-DAY STARTER PACK

— OTEZLA 30MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For oral ulcers associated with Behcet's disease: Trial of topical triamcinolone 0.1% oral paste was ineffective, not tolerated, or contraindicated. For Psoriatic Arthritis: intolerance to, or failure of therapy with, methotrexate (at least 20mg/week or maximally tolerated dose) is required. For Plaque Psoriasis: Failure of, or intolerance to, one of the following: a) methotrexate at a dose of 15mg/week (or maximally tolerated dose) OR b) soriatane.
Age Restrictions	
Prescriber Restriction	For oral ulcers associated with Behcet's disease and psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For oral ulcers associated with Behcet's disease: Diagnosis confirmed by the presence of oral ulcers AND at least two of the following: recurrent genital ulceration, eye lesions, skin lesions, positive pathergy test.

## Products Affected

— oxandrolone 10mg tab

— oxandrolone 2.5mg tab

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Breast or prostate cancer in men. Breast cancer in women with hypercalcemia. Pregnancy. Nephrosis or nephrotic phase of nephritis. Hypercalcemia.
Required Medical Info	Patient is receiving treatment as an adjunct therapy to promote weight gain and has one of the following: Extensive surgery, Chronic infections, Severe trauma, Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons and a nutritional consult was performed OR Oxandrin (oxandrolone) will be used to counterbalance protein catabolism associated with chronic corticosteroid administration OR Patient has bone pain associated with osteoporosis.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Osteoporosis bone pain: 1 month. Other diagnoses: 3 months.
Other Criteria	For renewal, patient has experienced an objective improvement (i.e. weight gain, increase in lean body mass, or reduction in muscle pain/weakness).

## Products Affected

— OXBRYTA 500MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1. Trial of maximally tolerated hydroxyurea dose was ineffective, not tolerated or contraindicated. 2. Member has had at least 1 vaso-occlusive crisis in the prior 12 months, while on hydroxyurea (if applicable). 3. If prescriber is a hematologist at a Sickle Cell Center of Excellence, criteria 1 and 2 may be bypassed (Documentation is provided of the name of the center of excellence).
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

- PALYNZIQ 10MG/0.5ML SYRINGE
- PALYNZIQ 20MG/ML SYRINGE

- PALYNZIQ 2.5MG/0.5ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Member is 18 years of age or older.
Prescriber Restriction	Prescribed by or in consultation with, a medical geneticist or metabolic physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– PANRETIN 0.1% GEL (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

## Products Affected

- PRALUENT 150MG/ML AUTO-INJECTOR
- REPATHA 140MG/ML AUTO-INJECTOR
- REPATHA 420MG/3.5ML CARTRIDGE

- PRALUENT 75MG/ML AUTO-INJECTOR
- REPATHA 140MG/ML SYRINGE

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

receptor mutation, AND 2) untreated total cholesterol greater 290 mg/dL or LDL-C greater 190 mg/dL, AND 3) either xanthomas present at 10 years of age or younger or atherosclerotic disease at 20 years of age or younger. Diagnosis of primary hyperlipidemia (other than HeFH and HoFH) includes documentation provided of the diagnosis, which may include, but is not limited to the following conditions: a) Familial hyperchylomicronemia or Buerger-Gruetz Syndrome, b) Familial Combined Hyperlipidemia, c) Familial dysbetalipoproteinemia, d) Familial Triglyceridemia, OR e) Endogenous Hypertriglyceridemia.

## Products Affected

- PEMAZYRE 13.5MG TAB (New Starts Only)
- PEMAZYRE 9MG TAB (New Starts Only)

- PEMAZYRE 4.5MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of FGFR2 fusion or other rearrangement, as detected by an FDA-approved test
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- PIQRAY 200MG DAILY DOSE PACK (New Starts Only)
- PIQRAY 300MG DAILY DOSE 150MG PACK (New Starts Only)

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

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of PIK3CA-mutation, by an FDA approved test.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

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

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

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

**Products Affected**

— PREVYMIS 240MG TAB

— PREVYMIS 480MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member will/has initiated Prevyomis within 30 days after an allogeneic hematopoietic stem cell transplant.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist, oncologist, transplant or infectious disease specialist.
Coverage Duration	Approved for 4 months subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– CRINONE 4% VAGINAL GEL

– CRINONE 8% VAGINAL GEL

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

## Products Affected

– PROLIA 60MG/ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For osteoporosis: Trial of an oral bisphosphonate was not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

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

- PROMACTA 12.5MG TAB
- PROMACTA 25MG TAB
- PROMACTA 75MG TAB

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

## Products Affected

– QINLOCK 50MG TAB (New Starts Only)

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

## Products Affected

— *quinine sulfate 324mg cap*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– RAVICTI 1.1GM/ML ORAL SOLN

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

## Products Affected

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

- RELISTOR 12MG/0.6ML SYRINGE

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

## Products Affected

— RETEVMO 40MG CAP (New Starts Only)

— RETEVMO 80MG CAP (New Starts Only)

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



## Products Affected

— *sildenafil 20mg tab*

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

**Products Affected**

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

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

## Products Affected

- REXULTI 0.25MG TAB (New Starts Only)
- REXULTI 1MG TAB (New Starts Only)
- REXULTI 3MG TAB (New Starts Only)

- REXULTI 0.5MG TAB (New Starts Only)
- REXULTI 2MG TAB (New Starts Only)
- REXULTI 4MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For schizophrenia, member has tried and failed 2 of the following: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone OR e) ziprasidone. For Major Depressive Disorder: member has tried and failed, or was intolerant to aripiprazole.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

– REYVOW 100MG TAB

– REYVOW 50MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trials of 2 different triptans were ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– RINVOQ 15MG ER TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Failure of, or intolerance to, therapy with methotrexate at a dose of at least 20mg/week (or maximally tolerated dose).
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis: Prescribed by, or in consultation with, a rheumatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— ROZLYTREK 100MG CAP (New Starts Only)

— ROZLYTREK 200MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of an FDA-approved test, showing one of the following: a) ROS1 rearrangement OR b) NTRK gene fusion mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

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

- RUBRACA 250MG TAB (New Starts Only)

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

## Products Affected

– RUZURGI 10MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) confirmed by one of the following: a) Presence of voltage-gated calcium channel antibodies OR b) electrophysiologic compound muscle action potential test findings are consistent with LEMS.



## Products Affected

– RYDAPT 25MG CAP (New Starts Only)

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

**Products Affected**

- *vigabatrin 500mg powder for oral soln (New Starts Only)*
- *vigadrone 500mg powder for oral soln (New Starts Only)*

- *vigabatrin 500mg tab (New Starts Only)*

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

## Products Affected

- asenapine 10mg sl tab (New Starts Only)
- asenapine 5mg sl tab (New Starts Only)
- SECUADO 5.7MG/24HR PATCH (New Starts Only)

- asenapine 2.5mg sl tab (New Starts Only)
- SECUADO 3.8MG/24HR PATCH (New Starts Only)
- SECUADO 7.6MG/24HR PATCH (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has tried and failed 2 of the following: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone OR e) ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- SAVELLA 100MG TAB
- SAVELLA 25MG TAB
- SAVELLA 50MG TAB

- SAVELLA 12.5MG TAB
- SAVELLA 4-WEEK TITRATION PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Use of monoamine oxidase inhibitors concomitantly or within 14 days.
Required Medical Info	Diagnosis of fibromyalgia AND patient had a previous trial with or has a contraindication, intolerance, or allergy to one of the following agents used for the treatment of fibromyalgia: tricyclic antidepressant, SNRI, SSRI, gabapentin.
Age Restrictions	18 years of age or older.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For renewal patient has had an improvement in pain, physical functioning, etc.

**Products Affected**

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

- SIGNIFOR 0.6MG/ML INJ

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

## Products Affected

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

- SIMPONI 100MG/ML SYRINGE
- SIMPONI 50MG/0.5ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Rheumatoid Arthritis (RA): Intolerance to, or failure of, therapy with 2 of the following: a) Humira, b) Enbrel, c) Rinvoq OR d) Xeljanz. For Ankylosing Spondylitis (AS): Intolerance to, or failure of, therapy with 2 of the following: a) Humira, b) Enbrel OR c) Taltz. For Psoriatic Arthritis: Intolerance to, or failure of, therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Stelara, e) Otezla OR f) Xeljanz. For Ulcerative Colitis: Intolerance to, or failure of, therapy with two of the following: a) Humira, b) Stelara OR c) Xeljanz.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For ulcerative colitis : Prescribed by, or in consultation with, a gastroenterology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

– SIRTURO 100MG TAB

– SIRTURO 20MG TAB

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

**Products Affected**

– SIVEXTRO 200MG INJ

– SIVEXTRO 200MG TAB

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



## Products Affected

- SKYRIZI 150MG DOSE PACK 75MG/0.83ML
- SKYRIZI 150MG/ML SYRINGE

- SKYRIZI 150MG/ML AUTO-INJECTOR

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis: Failure of, or intolerance to, therapy with one of the following is required: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) soriatane.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a dermatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– *diclofenac sodium 3% gel*

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

## Products Affected

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

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

**Products Affected**

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

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

## Products Affected

- SPRITAM 1000MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 500MG TAB FOR ORAL SUSP (New Starts Only)

- SPRITAM 250MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 750MG TAB FOR ORAL SUSP (New Starts Only)

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

## Products Affected

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

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

## Products Affected

- STELARA 45MG/0.5ML INJ
- STELARA 90MG/ML SYRINGE

- STELARA 45MG/0.5ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Plaque Psoriasis: Failure of, or intolerance to, therapy with one of the following required: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) soriatane. For Psoriatic Arthritis: Failure of, or intolerance to, one of the following required: a) methothrexate OR b) sulfasalazine. (Trial of methotrexate or sulfasalazine not required for AS with predominant axial involvement). For Ulcerative Colitis and Crohn's Disease: Failure of, or intolerance to, one of the following required: a) corticosteroid, b) azathioprine, c) methotrexate OR d) 6-mercaptopurine..
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's Disease and Ulcerative colitis: Prescribed by, or in consultation with, a gastroenterology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– STIVARGA 40MG TAB (New Starts Only)

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



## Products Affected

– SUCRAID 8500UNIT/ML ORAL SOLN

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

**Products Affected**

– SUNOSI 150MG TAB

– SUNOSI 75MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Failure of, or intolerance to, one of the following: a) modafinil OR b) armodafinil.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep medicine physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis.

## Products Affected

- *sunitinib 12.5mg cap (New Starts Only)*
- *sunitinib 37.5mg cap (New Starts Only)*

- *sunitinib 25mg cap (New Starts Only)*
- *sunitinib 50mg cap (New Starts Only)*

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

**Products Affected**

– SYMDEKO 50-75MG/75MG PACK

– SYMDEKO TAB 4-WEEK PACK

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

## Products Affected

– SYMPROIC 0.2MG TAB

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

## Products Affected

— *trientine 250mg cap*

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

## Products Affected

– TABRECTA 150MG TAB (New Starts Only)

– TABRECTA 200MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of MET exo 14 skipping mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– TAFINLAR 50MG CAP (New Starts Only)

– TAFINLAR 75MG CAP (New Starts Only)

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



## Products Affected

– TAGRISSO 40MG TAB (New Starts Only)

– TAGRISSO 80MG TAB (New Starts Only)

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

## Products Affected

– TALTZ 80MG/ML AUTO-INJECTOR

– TALTZ 80MG/ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Plaque Psoriasis: Requires failure of, or intolerance to therapy with, one of the following: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) soriatane. For Ankylosing Spondylitis (AS): Requires failure of, or intolerance to sulfasalazine. (Trial of sulfasalazine not required for AS with predominant axial involvement). For Psoriatic Arthritis: Requires failure of, or intolerance to, one of the following: a) methotrexate OR b) sulfasalazine. For Non-radiographic axial spondyloarthritis: Intolerance or failure of therapy with two non-steroidal anti-inflammatory drugs (NSAIDs).
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis, Non-radiographic axial spondyloarthritis and Ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– TALZENNA 0.25MG CAP (New Starts Only)

– TALZENNA 1MG CAP (New Starts Only)

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

## Products Affected

— erlotinib 100mg tab (*New Starts Only*)

— erlotinib 150mg tab (*New Starts Only*)

— erlotinib 25mg tab (*New Starts Only*)

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

## Products Affected

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

— TARGRETIN 1% GEL (New Starts Only)

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

## Products Affected

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

- TASIGNA 200MG CAP (New Starts Only)

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

## Products Affected

– TAVALISSE 100MG TAB

– TAVALISSE 150MG TAB

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

## Products Affected

- *tazarotene 0.1% cream*
- TAZORAC 0.05% GEL

- TAZORAC 0.05% CREAM
- TAZORAC 0.1% GEL

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy.
Required Medical Info	Diagnosis of acne vulgaris and patient has tried an adequate trial with at least one other topical acne product (e.g., benzoyl peroxide, salicylic acid, clindamycin, erythromycin, adapalene, azelaic acid, and/or tretinoin) OR Diagnosis of stable moderate to severe plaque psoriasis and 20% or less body surface area involvement and patient has a contraindication or tried adequate trial with at least one other topical psoriasis product (e.g., medium to high potency corticosteroid and/or vitamin D analogs) AND females of child-bearing potential are using adequate birth control measures during therapy.
Age Restrictions	12 years of age or older.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– TAZVERIK 200MG TAB (New Starts Only)

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

## Products Affected

– TEGSEDI 284MG/1.5ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by a neurologist, cardiologist, hematologist, or other specialist experienced in the diagnosis and treatment of hereditary transthyretin-mediated amyloidosis.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Hereditary transthyretin-mediated amyloidosis confirmed by genetic sequencing AND amyloidosis confirmed by positive tissue biopsy or laser capture tandem mass spectrometry.

## Products Affected

– TEPMETKO 225MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of MET exon 14 skipping mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- ANDRODERM 2MG/24HR PATCH
  - *testosterone 1% (25mg) gel packet*
  - *testosterone 1.62% (1.25gm) gel packet*
  - TESTOSTERONE 12.5MG/ACT GEL PUMP
  - *testosterone 30mg/act topical soln*
- ANDRODERM 4MG/24HR PATCH
  - *testosterone 1% (50mg) gel packet*
  - *testosterone 1.62% (2.5gm) gel packet*
  - *testosterone 20.25mg/act gel pump*

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

**Products Affected**

— *tetrabenazine 12.5mg tab*

— *tetrabenazine 25mg tab*

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

## Products Affected

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

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

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

## Products Affected

– TIBSOVO 250MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of IDH1 mutation as detected by an FDA approved test.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— *tobramycin 60mg/ml inh soln*

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



## Products Affected

— *bosentan 125mg tab*

— *bosentan 62.5mg tab*

— TRACLEER 32MG TAB FOR ORAL SUSP

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

## Products Affected

– TREMFYA 100MG/ML AUTO-INJECTOR

– TREMFYA 100MG/ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis: Intolerance to, or failure of, therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Skyrizi, e) Stelara OR f) Otezla. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Stelara e) Otezla OR f) Xeljanz
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis: Prescribed by, or in consultation, with a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– TRIKAFTA 100-50-75MG/150MG PACK

– TRIKAFTA 50MG-37.5MG-25MG/75MG TAB PACK

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

**Products Affected**

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

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

## Products Affected

– TRULANCE 3MG TAB

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

## Products Affected

- TRUSELTIQ 100MG CAP (New Starts Only)
- TRUSELTIQ 50MG CAP (New Starts Only)

- TRUSELTIQ 125MG CAP (New Starts Only)
- TRUSELTIQ 75MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of FGFR2 fusion or other rearrangement.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

## Products Affected

– TUKYSA 150MG TAB (New Starts Only)

– TUKYSA 50MG TAB (New Starts Only)

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

## Products Affected

– TURALIO 200MG CAP (New Starts Only)

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



## Products Affected

— *lapatinib 250mg tab (New Starts Only)*

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

## Products Affected

– TYMLOS 3120MCG/1.56ML PEN INJ

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

**Products Affected**

– UBRELVY 100MG TAB

– UBRELVY 50MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trials of 2 different triptans were ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

— *budesonide 9mg er tab*

— UCERIS 2MG/ACT RECTAL FOAM

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

## Products Affected

– UKONIQ 200MG TAB (New Starts Only)

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

## Products Affected

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

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

## Products Affected

– VALCHLOR 0.016% GEL (New Starts Only)

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

**Products Affected**

– VASCEPA 0.5GM CAP

– VASCEPA 1GM CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For hypertriglyceridemia: Documentation of persistent triglycerides above 150 mg/dL AND trial of, or intolerance to omega-3 acid ethyl esters.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a lipidologist or cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

- VELTASSA 16.8GM POWDER FOR ORAL SUSP
- VELTASSA 8.4GM POWDER FOR ORAL SUSP

- VELTASSA 25.2GM POWDER FOR ORAL SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has baseline persistent potassium level greater than 5.0 mmol/L.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist, cardiologist, or endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

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

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

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

**Products Affected**

– VENTAVIS 10MCG/ML INH SOLN

– VENTAVIS 20MCG/ML INH SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist or cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

**Products Affected**

- VERQUVO 10MG TAB
- VERQUVO 5MG TAB

- VERQUVO 2.5MG TAB

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

## Products Affected

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

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

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

**Products Affected**

– VIBERZI 100MG TAB

– VIBERZI 75MG TAB

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

## Products Affected

- VITRAKVI 100MG CAP (New Starts Only)
- VITRAKVI 25MG CAP (New Starts Only)

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

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

## Products Affected

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

- VIZIMPRO 30MG TAB (New Starts Only)

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



## Products Affected

- voriconazole 200mg inj
- voriconazole 40mg/ml susp

- voriconazole 200mg tab
- voriconazole 50mg tab

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

## Products Affected

– VOTRIENT 200MG TAB (New Starts Only)

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

## Products Affected

- VRAYLAR 1.5/3MG MIXED PACK (New Starts Only)
- VRAYLAR 3MG CAP (New Starts Only)
- VRAYLAR 6MG CAP (New Starts Only)
- VRAYLAR 1.5MG CAP (New Starts Only)
- VRAYLAR 4.5MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed 2 of the following: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone OR e) ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– VYNDAMAX 61MG CAP

– VYNDAQEL 20MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) Diagnosis confirmed by one of the following: i) cardiac biopsy with positive congo red staining and ATTR confirmation by mass spectrometry or immunofluorescence staining ii) Myocardial uptake of Tc-PYP demonstrated by a greater than 1.5 heart-to-contralateral ratio or grade 2 or greater visual evidence B) Absence of light-chain or other forms of amyloidosis confirmed by all of the following: i) Serum kappa/lambda free light chain ratio 0.26 to 1.65 ii) Absence of monoclonal protein via serum protein immunofixation iii) Absence of monoclonal protein via urine protein immunofixation.
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with, a cardiologist or other provider experienced in the treatment of cardiomyopathy of transthyretin-mediated amyloidosis.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

– WAKIX 17.8MG TAB

– WAKIX 4.45MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy: failure of, or intolerance to, both of the following: a) Sunosi AND b) either modafinil or armodafinil. For cataplexy, trial of other agents not required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep medicine physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For narcolepsy: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

## Products Affected

– WELIREG 40MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

## Products Affected

– XALKORI 200MG CAP (New Starts Only)

– XALKORI 250MG CAP (New Starts Only)

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

## Products Affected

– XATMEP 2.5MG/ML ORAL SOLN

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



## Products Affected

- XCOPRI 100MG TAB (New Starts Only)
- XCOPRI 150/200MG TITRATION PACK (New Starts Only)
- XCOPRI 200MG TAB (New Starts Only)
- XCOPRI 50MG TAB (New Starts Only)
- XCOPRI TAB 150/200MG PACK (New Starts Only)
- XCOPRI 12.5/25MG TITRATION PACK (New Starts Only)
- XCOPRI 150MG TAB (New Starts Only)
- XCOPRI 50/100MG TITRATION PACK (New Starts Only)
- XCOPRI TAB 100/150MG MAINTENANCE PACK (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed 2 of the following: a) lamotrigine b) carbamazepine c) levetiracetam d) oxcarbazepine e) phenytoin f) topiramate OR g) Vimpat (lacosamide).
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- XELJANZ 10MG TAB
- XELJANZ 11MG ER TAB
- XELJANZ 1MG/ML ORAL SOLN
- XELJANZ 22MG ER TAB
- XELJANZ 5MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 20mg/week required (or maximally tolerated dose). For Juvenile Idiopathic Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose). For Psoriatic Arthritis: Failure of, or intolerance to one of the following: a) methothrexate OR b) sulfasalazine. For Ulcerative Colitis: Failure of, or intolerance to one of the following: a) corticosteroid, b) azathioprine, c) methotrexate OR d) 6-mercaptopurine.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Juvenile idiopathic arthritis or Psoriatic Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist. For Ulcerative Colitis : Prescribed by, or in consultation with a Gastroenterology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— XENLETA 600MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for 1 month subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— XGEVA 120MG/1.7ML INJ

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

## Products Affected

— XIFAXAN 550MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For diagnosis of IBS-D, approval will increase quantity limit to 42 tablets over 14 days, maximum of three fills per contract year.

## Products Affected

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

- XOLAIR 150MG/ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe persistent asthma: There must be: A) Objective evidence of reversible airway obstruction B) Member IgE level must be provided and be between 30 IU/ml and 700 IU/ml (OR between 30 IU/mL and 1300 IU/mL for members aged 6 to 12 years) C) Member must have a positive skin test or RAST test for specific allergic sensitivity D) One of the following: i) Inadequately controlled asthma despite medium dose of inhaled corticosteroids for at least 3 months in combination with a trial of long-acting inhaled beta-agonists or a leukotriene modifier OR ii) systemic steroids or high dose inhaled corticosteroids are required to maintain adequate asthma control. For chronic idiopathic urticaria: one of the following: a) patient remains symptomatic despite H1 antihistamine treatment OR b) has intolerance or contraindication to H1 antihistamine treatment.
Age Restrictions	If for moderate to severe persistent asthma, patient must be at least 6 years old. If for chronic idiopathic urticaria, patient must be at least 12 years old.
Prescriber Restriction	Prescribed by, or in consultation with, an allergy specialist, pulmonary specialist, dermatology specialist, otolaryngologist, or immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— XOSPATA 40MG TAB (New Starts Only)

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

## Products Affected

- XPOVIO 100MG ONCE WEEKLY CARTON (8-PACK) (New Starts On
- XPOVIO 40MG TWICE WEEKLY CARTON (8-PACK) (New Starts On
- XPOVIO 60MG TWICE WEEKLY PACK (New Starts Only)
- XPOVIO 80MG ONCE WEEKLY CARTON (8-PACK) (New Starts Only
- XPOVIO 40MG ONCE WEEKLY CARTON (4-PACK) (New Starts Only
- XPOVIO 60MG ONCE WEEKLY CARTON (4-PACK) (New Starts Only
- XPOVIO 80 MG TWICE WEEKLY (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of prior therapies required. For multiple myeloma: If used in combination with bortezomib and dexamethasone, trial of at least one prior therapy. If used in combination with dexamethasone alone, prior therapies include at least 4 therapies, including at least 2 proteasome inhibitors, 2 immunomodulatory agents and an anti-CD38 monoclonal antibody. For diffuse large B-cell lymphoma: Trial of at least 2 lines of prior systemic therapy.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– XTANDI 40MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic castration-resistant prostate cancer (mCRPC) and metastatic castration-sensitive prostate cancer (mCSPC): failure of, intolerance or contraindication to, abiraterone (Zytiga equivalent) required. For nonmetastatic castration-resistant prostate cancer (nmCRPC): failure of, or intolerance to, both of the following: a) Nubeqa and b) Erleada.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– XYREM 500MG/ML ORAL SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy: failure of, or intolerance to, both of the following: a) Sunosi AND b) either modafinil or armodafinil. For cataplexy, trial of other agents not required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep medicine physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For narcolepsy: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

## Products Affected

– *miglustat 100mg cap*

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

## Products Affected

– ZEJULA 100MG CAP (New Starts Only)

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

## Products Affected

– ZELBORAF 240MG TAB (New Starts Only)

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

## Products Affected

– ZOLINZA 100MG CAP (New Starts Only)

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

## Products Affected

– ZYDELIG 100MG TAB (New Starts Only)

– ZYDELIG 150MG TAB (New Starts Only)

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

## Products Affected

– ZYKADIA 150MG TAB (New Starts Only)

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