2019 PRIOR AUTHORIZATION CRITERIA

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Prior Authorization Group – **Acthar HP Gel PA**

Drug Name(s):
H.P. ACTHAR GEL

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of infantile spasm OR
    b. Patient has a diagnosis of nephrotic syndrome AND ONE of the following:
        i. Patient has failed a conventional agent (i.e. prednisone, cyclophosphamide, tacrolimus) for the requested indication OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a conventional agent OR
    c. Patient has a diagnosis of multiple sclerosis AND ALL of the following:
        i. Patient is experiencing an acute exacerbation AND
        ii. If indicated, there is evidence of a claim that the patient is currently on a disease modifying drug (DMD) within the past 90 days (e.g. Aubagio, Avonex, Betaseron, Extavia, Gilenya, glatiramer (i.e. Copaxone, Glatopa), Lemtrada, mitoxantrone, Ocrevus, Plegridy, Rebif, Tecfidera, or Tysabri) to control disease progression OR has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a DMD AND
        iii. Patient has failed corticosteroid therapy within the last 30 days or has an FDA labeled contraindication to corticosteroid therapy (e.g. methylprednisolone 1gm IV for 3-5 days) OR

Criteria continues: see Other Criteria

Age Restrictions:
For diagnosis of infantile spasm, patient is less than 24 months of age. For diagnosis of nephrotic syndrome, patient is greater than 2 years of age.

Prescriber Restrictions:

Coverage Duration:
6 months for infantile spasm, 1 month for all other indications

Other Criteria:

d. Patient has a diagnosis of rheumatic disorder (e.g. ankylosing spondylitis, juvenile idiopathic arthritis, juvenile rheumatoid arthritis, psoriatic arthritis, rheumatoid arthritis) AND BOTH of the following:

i. If indicated, there is evidence of a claim that the patient is currently being treated with a conventional agent within the past 90 days (e.g. DMARD [methotrexate, leflunomide], biologics [Humira, Enbrel]) to control disease progression OR has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a conventional agent AND

ii. Patient has failed corticosteroid therapy within the last 30 days or has an FDA labeled contraindication to corticosteroid therapy (e.g. methylprednisolone 1gm IV for 3-5 days) OR

e. Patient has a diagnosis of systemic lupus erythematosus (SLE) disease AND ALL of the following:

i. Patient has a history of positive antinuclear antibody (ANA) and/or positive anti-dsDNA results AND

ii. Patient has a history of 3 other SLE diagnostic criteria (i.e. malar rash, discoid rash, photosensitivity, oral ulcers, nonerosive arthritis, serositis [e.g. pleuritis/pericarditis], renal disorder [e.g. persistent proteinuria greater than 0.5 grams/day or cellular casts], hematologic disorder [e.g. hemolytic anemia (with reticulocytosis), leukopenia, lymphopenia, or thrombocytopenia], and/or immunologic disorder [e.g. positive finding of antiphospholipid antibodies or anti-Sm antibodies]) AND

iii. ONE of the following:

1. There is evidence of a claim that the patient is currently on a SLE treatment regimen within the past 90 days comprised of at least ONE of the following: corticosteroids (e.g. methylprednisolone, prednisone), antimalarials (e.g. hydroxychloroquine, chloroquine), prescription nonsteroidal anti-inflammatory drugs (NSAIDS) (e.g. ibuprofen, naproxen), and/or immunosuppressive (e.g. azathioprine, methotrexate, cyclosporine, or oral cyclophosphamide) OR

2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to any standard of care drug class listed above OR

f. Patient has another FDA approved indication AND

i. Patient has failed corticosteroid therapy within the last 30 days or has an FDA labeled contraindication to corticosteroids therapy (e.g. methylprednisolone 1gm IV for 3-5 days) OR

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

i. Patient has failed corticosteroid therapy within the last 30 days or has an FDA labeled contraindication to corticosteroids therapy (e.g. methylprednisolone 1gm IV for 3-5 days) AND

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

Prior Authorization Group – **Actimmune PA**

Drug Name(s):
ACTIMMUNE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
This program applies to new starts only.

Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. The dose requested is within the FDA labeled or CMS approved compendia dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Aimovig PA**

Drug Name(s):
AIMOVIG

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of migraine AND
2. Patient has 4 migraine headaches or more per month AND
3. ONE of the following:
    a. Patient has failed at least TWO conventional migraine prophylaxis agents from TWO different classes (e.g. beta blockers [propranolol], anticonvulsants [divalproex, topiramate]) OR
    b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to TWO conventional migraine prophylaxis agents from TWO different classes AND
4. ONE of the following:
    a. Patient is NOT currently taking another calcitonin gene-related peptide (CGRP) agent OR
    b. Patient is currently being treated with another calcitonin gene-related peptide (CGRP) agent AND will discontinue prior to initiating therapy with the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's prior authorization criteria AND
2. Patient has a diagnosis of migraine AND
3. Patient has shown clinical benefit with the requested agent AND
4. ONE of the following:
    a. Patient is NOT currently taking another calcitonin gene-related peptide (CGRP) agent OR
    b. Patient is currently being treated with another calcitonin gene-related peptide (CGRP) agent AND will discontinue prior to continuing therapy with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Ajovy PA**

Drug Name(s):
AJOVY

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of migraine AND
2. Patient has 4 migraine headaches or more per month AND
3. ONE of the following:
    a. Patient has failed at least TWO conventional migraine prophylaxis agents from TWO different classes (e.g. beta blockers [propranolol], anticonvulsants [divalproex, topiramate]) OR
    b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to TWO conventional migraine prophylaxis agents from TWO different classes AND
4. ONE of the following:
    a. Patient is NOT currently taking another calcitonin gene-related peptide (CGRP) agent OR
    b. Patient is currently being treated with another calcitonin gene-related peptide (CGRP) agent AND will discontinue prior to initiating therapy with the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's prior authorization criteria AND
2. Patient has a diagnosis of migraine AND
3. Patient has shown clinical benefit with the requested agent AND
4. ONE of the following:
    a. Patient is NOT currently taking another calcitonin gene-related peptide (CGRP) agent OR
    b. Patient is currently being treated with another calcitonin gene-related peptide (CGRP) agent AND will discontinue prior to continuing therapy with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Alpha-1-Proteinase Inhibitor PA - Aralast/Prolastin-C/Zemaira**

Drug Name(s):
ARALAST NP
PROLASTIN-C
ZEMAIRA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of alpha-1 antitrypsin deficiency (AATD) AND
2. Patient has a pre-treatment serum alpha-1 antitrypsin (AAT) level less than 11 µM/L (80 mg/dL by immunodiffusion or 57 mg/dL using nephelometry) AND
3. Patient has one of the following phenotype variants associated with AATD: PiZZ, PiSZ, PiZ/Null or PiNull/Null AND
4. Patient has emphysema with a documented baseline FEV1 of 65% or less of predicted AND
5. The dose requested is within the FDA labeled dose

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of alpha-1 antitrypsin deficiency (AATD) with clinically evident emphysema AND
3. Patient has shown clinical benefit with the requested agent AND
4. The dose requested is within the FDA labeled dose

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Alpha-1-Proteinase Inhibitor PA - Glassia**

Drug Name(s):
GLASSIA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of alpha-1 antitrypsin deficiency (AATD) AND
2. Patient has a pre-treatment serum alpha-1 antitrypsin (AAT) level less than 11 µM/L (80 mg/dL by immunodiffusion or 57 mg/dL using nephelometry) AND
3. Patient has one of the following phenotype variants associated with AATD: PiZZ, PiSZ, PiZ/Null or PiNull/Null AND
4. Patient has emphysema with a documented baseline FEV1 of 65% or less of predicted AND
5. The dose requested is within the FDA labeled dose

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of alpha-1 antitrypsin deficiency (AATD) with clinically evident emphysema AND
3. Patient has shown clinical benefit with the requested agent AND
4. The dose requested is within the FDA labeled dose

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Amantadine ER PA - Gocovri**

Drug Name(s):
GOCOVRI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of Parkinson's disease AND
2. The requested agent will be used for the treatment of dyskinesia AND
3. Patient is currently receiving levodopa-based therapy

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. neurologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Amantadine ER PA - Osmolex ER**

Drug Name(s):
OSMOLEX ER

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ONE of the following:
A. Patient has a diagnosis of Parkinson's disease OR
B. Patient has a diagnosis of drug-induced extrapyramidal reaction AND the following:
    i. Prescriber has assessed and adjusted, if applicable, any medications known to cause extrapyramidal symptoms

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. neurologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Amitiza PA**

Drug Name(s):
AMITIZA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has ONE of the following diagnoses:
    A. Chronic idiopathic constipation with documentation of symptoms for at least 3 months OR
    B. Irritable bowel syndrome with constipation with documentation of symptoms for at least 3 months AND the patient is female OR
    C. Opioid-induced constipation with chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment AND BOTH of the following:
        i. Patient has chronic use of an opioid agent within the past 90 days AND
        ii. Patient has NOT received methadone within the past 90 days AND
2. ONE of the following:
    A. Patient has a medication history that includes lactulose or polyethylene glycol 3350 OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to lactulose or polyethylene glycol 3350

Age Restrictions:
Patient is 18 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Anabolic Steroid PA - Danazol**

Drug Name(s):
danazol capsule

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has ONE of the following diagnoses:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. Patient is NOT currently treated with another androgen or anabolic steroid within the past 90 days OR
    b. The current androgen or anabolic steroid will be discontinued prior to starting the requested agent OR
    c. Prescriber has submitted documentation in support of therapy with more than one agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Anabolic Steroid PA - Oxandrolone**

Drug Name(s):
oxandrolone tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has ONE of the following diagnoses:
    a. Patient has AIDS/HIV-associated wasting syndrome (defined as unexplained involuntary weight loss greater than 10% baseline body weight with obvious wasting or body mass index less than 18.5 kg/m2) AND all other causes of weight loss have been ruled out OR
    b. Patient is a female child or adolescent with Turner syndrome AND is currently receiving growth hormone OR
    c. Patient has weight loss following extensive surgery, chronic infections, or severe trauma OR
    d. Patient has chronic pain from osteoporosis OR
    e. Patient is on long-term administration of oral or injectable corticosteroids AND
2. ONE of the following:
    a. Patient is NOT currently treated with another androgen or anabolic steroid within the past 90 days OR
    b. The current androgen or anabolic steroid will be discontinued prior to starting the requested agent OR
    c. Prescriber has submitted documentation in support of therapy with more than one agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Anabolic Steroid PA - Oxymetholone**

Drug Name(s):
ANADROL-50

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    a. Patient has anemia caused by deficient red cell production, including acquired aplastic anemia, congenital aplastic anemia, myelofibrosis and the hypoplastic anemias due to the administration of myelotoxic drugs OR
    b. Patient has anemia associated with chronic renal failure AND ONE of the following:
        i. Patient's medication history indicates previous use of an erythropoiesis-stimulating agent OR
        ii. Patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to an erythropoiesis-stimulating agent AND
2. Patient has a hematocrit (Hct) value less than 30% AND
3. ONE of the following:
    a. Patient is NOT currently treated with another androgen or anabolic steroid within the past 90 days OR
    b. The current androgen or anabolic steroid will be discontinued prior to starting the requested agent OR
    c. Prescriber has submitted documentation in support of therapy with more than one agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Androgen Injectable PA - Aveed**

Drug Name(s):
AVEED

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient is a male with a diagnosis of primary or secondary (hypogonadotropic) hypogonadism AND
2. Patient has a measured current or pretreatment total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR a free serum testosterone level that is below the testing laboratory's lower limit of the normal range AND
3. ONE of the following:
    a. Patient is NOT currently treated with another androgen or anabolic steroid within the past 90 days OR
    b. The current androgen or anabolic steroid will be discontinued prior to starting the requested agent OR
    c. Prescriber has submitted documentation in support of therapy with more than one agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Androgen Injectable PA - testosterone cypionate**

Drug Name(s):
DEPO-TESTOSTERONE
testosterone cypionate injection

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    a. Patient is a male with AIDS/HIV-associated wasting syndrome, defined as unexplained involuntary weight loss (greater than 10% baseline body weight) with obvious wasting OR body mass index less than 18.5 kg/m2 AND all other causes of weight loss have been ruled out OR
    b. Patient is a female with metastatic/inoperable breast cancer OR
    c. Patient is a male with primary or secondary (hypogonadotropic) hypogonadism OR
    d. Patient is an adolescent male with delayed puberty AND
2. Males only: Patient has a measured current or pretreatment total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR a free serum testosterone level that is below the testing laboratory's lower limit of the normal range AND
3. ONE of the following:
    a. Patient is NOT currently treated with another androgen or anabolic steroid within the past 90 days OR
    b. The current androgen or anabolic steroid will be discontinued prior to starting the requested agent OR
    c. Prescriber has submitted documentation in support of therapy with more than one agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be 6 months for delayed puberty, 12 months for all other indications

Other Criteria:

Prior Authorization Group – **Androgen Injectable PA - testosterone enanthate**

Drug Name(s):
testosterone enanthate injection

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    a. Patient is a male with AIDS/HIV-associated wasting syndrome, defined as unexplained involuntary weight loss (greater than 10% baseline body weight) with obvious wasting OR body mass index less than 18.5 kg/m2 AND all other causes of weight loss have been ruled out OR
    b. Patient is a female with metastatic/inoperable breast cancer OR
    c. Patient is a male with primary or secondary (hypogonadotropic) hypogonadism OR
    d. Patient is an adolescent male with delayed puberty AND
2. Males only: Patient has a measured current or pretreatment total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR a free serum testosterone level that is below the testing laboratory's lower limit of the normal range AND
3. ONE of the following:
    a. Patient is NOT currently treated with another androgen or anabolic steroid within the past 90 days OR
    b. The current androgen or anabolic steroid will be discontinued prior to starting the requested agent OR
    c. Prescriber has submitted documentation in support of therapy with more than one agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be 6 months for delayed puberty, 12 months for all other indications

Other Criteria:

Prior Authorization Group – **Androgen Injectable PA - Xyosted**

Drug Name(s):
XYOSTED

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    a. Patient is a male with AIDS/HIV-associated wasting syndrome, defined as unexplained involuntary weight loss (greater than 10% baseline body weight) with obvious wasting OR body mass index less than 18.5 kg/m2 AND all other causes of weight loss have been ruled out OR
    b. Patient is a male with primary or secondary (hypogonadotropic) hypogonadism AND
2. Males only: Patient has a measured current or pretreatment total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR a free serum testosterone level that is below the testing laboratory's lower limit of the normal range AND
3. ONE of the following:
    a. Patient is NOT currently treated with another androgen or anabolic steroid within the past 90 days OR
    b. The current androgen or anabolic steroid will be discontinued prior to starting the requested agent OR
    c. Prescriber has submitted documentation in support of therapy with more than one agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Androgen Oral PA**

Drug Name(s):
ANDROXY
METHITEST
METHYLTESTOSTERONE 10 mg capsule

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    a. Patient is a male with cryptorchidism OR
    b. Patient is a male with hypogonadism OR
    c. Patient is an adolescent male with delayed puberty OR
    d. Patient is a female with metastatic/inoperable breast cancer AND
2. Males only: Patient has a measured current or pretreatment total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR a free serum testosterone level that is below the testing laboratory's lower limit of the normal range AND
3. ONE of the following:
    a. Patient is NOT currently treated with another androgen or anabolic steroid within the past 90 days OR
    b. The current androgen or anabolic steroid will be discontinued prior to starting the requested agent OR
    c. Prescriber has submitted documentation in support of therapy with more than one agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be 6 months for delayed puberty, 12 months for all other indications

Other Criteria:

Prior Authorization Group – **Androgen Topical PA**

Drug Name(s):

ANDRODERM
ANDROGEL 1%
ANDROGEL 1.62%
AXIRON
FORTESTA
NATESTO
STRIANT
TESTIM
testosterone 1% gel
testosterone 1.62% gel
testosterone 10 mg/act gel
testosterone 30 mg/actuation solution
VOGELXO
VOGELXO PUMP

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

FDA labeled contraindication(s) to the requested agent

Required Medical:

Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    a. Patient has AIDS/HIV-associated wasting syndrome, defined as unexplained involuntary weight loss (greater than 10% baseline body weight) with obvious wasting OR body mass index less than 18.5 kg/m2 AND all other causes of weight loss have been ruled out OR
    b. Patient is a male with primary or secondary (hypogonadotropic) hypogonadism AND
2. Males only: Patient has a measured current or pretreatment total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR a free serum testosterone level that is below the testing laboratory's lower limit of the normal range AND
3. ONE of the following:
    a. Patient is NOT currently treated with another androgen or anabolic steroid within the past 90 days OR
    b. The current androgen or anabolic steroid will be discontinued prior to starting the requested agent OR

c. Prescriber has submitted documentation in support of therapy with more than one agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Antipsychotics PA**

Drug Name(s):
ABILIFY MAINTENA
ABILIFY MYCITE
ABILIFY tablet
ADASUVE
aripiprazole ODT
aripiprazole solution, tablet
ARISTADA
ARISTADA INITIO
CHLORPROMAZINE injection
chlorpromazine tablet
clozapine ODT
clozapine tablet
CLOZARIL
FANAPT
FANAPT TITRATION PACK
FAZACLO ODT
FLUPHENAZINE concentrate, elixir, injection
fluphenazine decanoate 25 mg/mL injection
fluphenazine tablet
GEODON
HALDOL
HALDOL DECANOATE
haloperidol concentrate, injection, tablet
haloperidol decanoate injection
INVEGA
INVEGA SUSTENNA
INVEGA TRINZA
LATUDA
loxapine capsule
MOLINDONE
olanzapine injection, tablet
olanzapine ODT
olanzapine/fluoxetine capsule
paliperidone ER tablet
perphenazine tablet
PERSERIS
quetiapine ER tablet
quetiapine tablet
REXULTI
RISPERDAL
RISPERDAL CONSTA
RISPERDAL M-TAB 2 mg
risperidone ODT
risperidone solution, tablet

SAPHRIS
SEROQUEL
SEROQUEL XR
SYMBYAX
thioridazine tablet
thiothixene capsule
trifluoperazine tablet
VERSACLOZ
VRAYLAR
ziprasidone capsule
ZYPREXA
ZYPREXA RELPREVV
ZYPREXA ZYDIS

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:

Program applies to new starts only. PA does NOT apply to patients less than 65 years of age.

Criteria for approval require BOTH of the following:

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

Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Apokyn PA**

Drug Name(s):
APOKYN

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
Receiving a 5-HT3 antagonist (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron) concomitantly with the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. The requested agent will be used to treat acute, intermittent hypomobility, "off" episodes (muscle stiffness, slow movements, or difficulty starting movement) associated with advanced Parkinson's disease AND
2. There is evidence of a claim that the patient is receiving concurrent therapy for Parkinson's disease (e.g., levodopa, dopamine agonist, or monoamine oxidase B inhibitor) within the past 30 days

Age Restrictions:

Prescriber Restrictions:
Prescriber is a neurologist or the prescriber has consulted with a neurologist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Arcalyst PA**

Drug Name(s):
ARCALYST

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
An active or chronic infection (e.g. tuberculosis, HIV, hepatitis B/C)

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has been diagnosed with Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Auto-inflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS) AND
2. ONE of the following:
    A. Patient is NOT currently being treated with another biologic agent OR
    B. Patient is currently being treated with another biologic agent and the agent will be discontinued prior to initiating the requested agent

Age Restrictions:
Patient is at least 12 years of age

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Armodafinil PA**

Drug Name(s):
armodafinil tablet
NUVIGIL

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. Patient is receiving only one of the listed agents, armodafinil OR modafinil, within the past 90 days OR
    B. Patient has been treated with modafinil within the past 90 days AND will discontinue prior to starting the requested agent

Age Restrictions:
Patient is 17 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Atopic Dermatitis PA - Elidel**

Drug Name(s):
ELIDEL
pimecrolimus 1% cream

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has a diagnosis of atopic dermatitis or vulvar lichen sclerosus AND ONE of the following:
    A. Patient has had a trial and failure of a topical corticosteroid or topical corticosteroid combination preparation (e.g. clobetasol, hydrocortisone, triamcinolone) OR
    B. Patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to a topical corticosteroid or topical corticosteroid combination preparation OR
2. Patient has a diagnosis of facial seborrheic dermatitis associated with HIV infection AND BOTH of the following:
    A. Patient is currently on an antiretroviral treatment regimen AND
    B. ONE of the following:
        i. Patient has had a trial and failure of a topical corticosteroid or topical antifungal treatment (e.g. hydrocortisone, triamcinolone, ketoconazole, nystatin-triamcinolone) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to a topical corticosteroid or topical antifungal treatment OR
3. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Atopic Dermatitis PA - Eucrisa**

Drug Name(s):
EUCRISA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of atopic dermatitis AND
2. ONE of the following:
    A. Patient has had a trial and failure with a topical corticosteroid or topical corticosteroid combination preparation (e.g. clobetasol, hydrocortisone, triamcinolone) OR
    B. Patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to a topical corticosteroid or topical corticosteroid combination preparation

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Atopic Dermatitis PA - Tacrolimus**

Drug Name(s):
PROTOPIC
tacrolimus ointment

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has a diagnosis of atopic dermatitis AND ONE of the following:
    A. Patient has had a trial and failure with a topical corticosteroid or topical corticosteroid combination preparation (e.g. clobetasol, hydrocortisone, triamcinolone) OR
    B. Patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to a topical corticosteroid or topical corticosteroid combination preparation OR
2. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Auryxia PA**

Drug Name(s):
AURYXIA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
Requested agent will be used as iron replacement therapy to treat iron deficiency anemia AND FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require the following:
1. Patient has a diagnosis of hyperphosphatemia in chronic kidney disease on dialysis

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Austedo PA**

Drug Name(s):
AUSTEDO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of chorea associated with Huntington's disease AND BOTH of the following:
        i. If the patient has a current diagnosis of depression, the patient is being treated for depression AND
        ii. If the patient has a diagnosis of passive suicidal ideation, the patient must not be actively suicidal OR
    B. Patient has a diagnosis of tardive dyskinesia AND ONE of the following:
        i. Prescriber has reduced the dose of or discontinued any medications known to cause tardive dyskinesia (i.e., dopamine receptor blocking agents) OR
        ii. Prescriber has provided clinical rationale indicating that a reduced dose or discontinuation of the offending agent is not appropriate AND
2. Patient is NOT receiving a monoamine oxidase inhibitor (MAOI) OR the patient's MAOI will be discontinued at least 14 days before starting therapy with the requested agent AND
3. Patient is NOT receiving reserpine OR the patient's reserpine will be discontinued at least 20 days before starting therapy with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benign Prostatic Hyperplasia PA - Tadalafil**

Drug Name(s):
CIALIS 2.5 mg, 5 mg tablet
tadalafil 2.5 mg, 5 mg tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
Requested agent will be used to treat erectile dysfunction AND FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require the following:
1. Patient has a diagnosis of benign prostatic hyperplasia (BPH) AND ONE of the following:
    a. Patient has tried and failed two alpha blocker agents (e.g. terazosin, doxazosin, tamsulosin) OR
    b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to two alpha blocker agents (e.g. terazosin, doxazosin, tamsulosin)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benlysta PA**

Drug Name(s):
BENLYSTA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of active systemic lupus erythematosus (SLE) disease AND
2. Patient has a history of positive antinuclear antibody (ANA) and/or positive anti-dsDNA results AND
3. Patient has a history of 3 other SLE diagnostic criteria (i.e. malar rash, discoid rash, photosensitivity, oral ulcers, nonerosive arthritis, serositis [e.g. pleuritis/pericarditis], renal disorder [e.g. persistent proteinuria greater than 0.5 grams/day or cellular casts], hematologic disorder [e.g. hemolytic anemia (with reticulocytosis), leukopenia, lymphopenia, or thrombocytopenia], and/or immunologic disorder [e.g. positive finding of antiphospholipid antibodies or anti-Sm antibodies]) AND
4. ONE of the following:
    A. There is evidence of a claim that the patient is currently on SLE treatment regimen within the past 90 days comprised of at least ONE of the following: corticosteroids (e.g. methylprednisolone, prednisone), antimalarials (e.g. hydroxychloroquine, chloroquine), prescription nonsteroidal anti-inflammatory drugs (NSAIDS) (e.g. ibuprofen, naproxen), and/or immunosuppressives (e.g. azathioprine, methotrexate, cyclosporine, or oral cyclophosphamide) OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to any standard of care drug classes listed above AND
5. ONE of the following:
    A. Patient has NOT been treated with intravenous (IV) cyclophosphamide in the past 30 days OR
    B. Patient has been treated with IV cyclophosphamide in the past 30 days AND will discontinue prior to starting the requested agent AND
6. ONE of the following:
    A. Patient has NOT been treated with another biologic agent in the past 30 days OR
    B. Patient has been treated with another biologic agent in the past 30 days AND will discontinue prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has diagnosis of active systemic lupus erythematosus (SLE) disease AND
3. ONE of the following:
    A. There is evidence of a claim that the patient is currently on SLE treatment regimen within the past 90 days comprised of at least ONE of the following: corticosteroids (e.g. methylprednisolone, prednisone), antimalarials (e.g. hydroxychloroquine, chloroquine), prescription nonsteroidal anti-inflammatory drugs (NSAIDS) (e.g. ibuprofen, naproxen), and/or immunosuppressives (e.g. azathioprine, methotrexate, cyclosporine, or oral cyclophosphamide) OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to any standard of care drug classes listed above AND
4. Patient has had a decrease in symptoms or stabilization in at least ONE SLE diagnostic criteria (i.e. malar rash, discoid rash, photosensitivity, oral ulcers, nonerosive arthritis, serositis [e.g. pleuritis/pericarditis], renal disorder [e.g persistent proteinuria greater than 0.5 grams/day or cellular casts], hematologic disorder [e.g. hemolytic anemia (with reticulocytosis), leukopenia, lymphopenia, or thrombocytopenia], and/or immunologic disorder [e.g. positive finding of antiphopholipid antibodies or anti-Sm antibodies]) AND
5. ONE of the following:
    A. Patient has NOT been treated with intravenous (IV) cyclophosphamide in the past 30 days OR
    B. Patient has been treated with IV cyclophosphamide in the past 30 days AND will discontinue prior to starting the requested agent AND
6. ONE of the following:
    A. Patient has NOT been treated with another biologic agent in the past 30 days OR
    B. Patient has been treated with another biologic agent in the past 30 days AND will discontinue prior to starting the requested agent

Prior Authorization Group – **Benzodiazepines PA - Alprazolam**

Drug Name(s):

alprazolam ER tablet
ALPRAZOLAM INTENSOL
alprazolam ODT
alprazolam tablet
XANAX
XANAX XR

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:

Program applies to new starts only.

Criteria for approval require ONE of the following:
A. BOTH of the following:
    i. ONE of the following:
        a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
        b. Prescriber states the patient is currently using the requested agent AND
    ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
B. BOTH of the following:
    i. Patient has ONE of the following diagnoses:
        a. Anxiety disorder or panic disorder AND ONE of the following:
            1) Patient's medication history includes use of a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
            2) Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to formulary SSRIs or SNRIs OR
        b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
    ii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benzodiazepines PA - Chlordiazepoxide**

Drug Name(s):
chlordiazepoxide capsule

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.

Criteria for approval require ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
b. Prescriber states the patient is currently using the requested agent AND
ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
B. BOTH of the following:
i. Patient has ONE of the following diagnoses:
a. Anxiety disorder AND ONE of the following:
1) Patient's medication history includes use of a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
2) Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to formulary SSRIs or SNRIs OR
b. Alcohol withdrawal OR
c. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
ii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benzodiazepines PA - Chlordiazepoxide/amitriptyline**

Drug Name(s):
CHLORDIAZEPOXIDE/AMITRIPTYLINE tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.

Criteria for approval require ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
b. Prescriber states the patient is currently using the requested agent AND
ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
B. ALL of the following:
i. Patient has ONE of the following diagnoses:
a. Moderate to severe depression with moderate to severe anxiety AND ONE of the following:
1) Patient's medication history includes use of a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
2) Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to formulary SSRIs or SNRIs OR
b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
ii. ONE of the following:
a. Patient has not taken a monoamine oxidase inhibitor (MAOI) in the past 30 days OR
b. Patient has taken an MAOI in the past 30 days AND will discontinue at least 14 days prior to starting the requested agent AND
iii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benzodiazepines PA - Clonazepam**

Drug Name(s):
clonazepam ODT
clonazepam tablet
KLONOPIN

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.

Criteria for approval require ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
b. Prescriber states the patient is currently using the requested agent AND
ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
B. BOTH of the following:
i. Patient has ONE of the following diagnoses:
a. Seizure disorder OR
b. Panic disorder AND ONE of the following:
1) Patient's medication history includes use of a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
2) Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to formulary SSRIs or SNRIs OR
c. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
ii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benzodiazepines PA - Clorazepate**

Drug Name(s):
clorazepate tablet
TRANXENE T

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.

Criteria for approval require ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
b. Prescriber states the patient is currently using the requested agent AND
ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
B. BOTH of the following:
i. Patient has ONE of the following diagnoses:
a. Seizure disorder OR
b. Anxiety disorder AND ONE of the following:
1) Patient's medication history includes use of a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
2) Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to formulary SSRIs or SNRIs OR
c. Alcohol withdrawal OR
d. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
ii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benzodiazepines PA - Diazepam**

Drug Name(s):

DIAZEPAM 1 mg/mL oral solution
diazepam intensol concentrate
diazepam tablet
VALIUM

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:

Program applies to new starts only.

Criteria for approval require ONE of the following:
A. BOTH of the following:
- i. ONE of the following:
  - a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
  - b. Prescriber states the patient is currently using the requested agent AND
- ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR

B. BOTH of the following:
- i. Patient has ONE of the following diagnoses:
  - a. Seizure disorder OR
  - b. Anxiety disorder AND ONE of the following:
    - 1) Patient's medication history includes use of a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
    - 2) Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to formulary SSRIs or SNRIs OR
  - c. Skeletal muscle spasms OR
  - d. Alcohol withdrawal OR
  - e. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
- ii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benzodiazepines PA - Estazolam**

Drug Name(s):
estazolam tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has a diagnosis of insomnia OR
2. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benzodiazepines PA - Flurazepam**

Drug Name(s):
FLURAZEPAM

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has a diagnosis of insomnia OR
2. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benzodiazepines PA - Lorazepam**

Drug Name(s):
ATIVAN tablet
lorazepam concentrate, tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.

Criteria for approval require ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
b. Prescriber states the patient is currently using the requested agent AND
ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
B. BOTH of the following:
i. Patient has ONE of the following diagnoses:
a. Anxiety disorder AND ONE of the following:
1) Patient's medication history includes use of a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
2) Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to formulary SSRIs or SNRIs OR
b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
ii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benzodiazepines PA - Onfi**

Drug Name(s):
clobazam suspension, tablet
ONFI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.

Criteria for approval require ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
b. Prescriber states the patient is currently using the requested agent AND
ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
B. BOTH of the following:
i. Patient has ONE of the following diagnoses:
a. Seizure disorder OR
b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
ii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benzodiazepines PA - Oxazepam**

Drug Name(s):
oxazepam capsule

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.

Criteria for approval require ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
b. Prescriber states the patient is currently using the requested agent AND
ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
B. BOTH of the following:
i. Patient has ONE of the following diagnoses:
a. Anxiety disorder AND ONE of the following:
1) Patient's medication history includes use of a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
2) Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to formulary SSRIs or SNRIs OR
b. Alcohol withdrawal OR
c. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
ii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benzodiazepines PA - Temazepam**

Drug Name(s):
RESTORIL
temazepam capsule

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has a diagnosis of insomnia OR
2. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benzodiazepines PA - Triazolam**

Drug Name(s):
HALCION
triazolam tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has a diagnosis of insomnia OR
2. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Benzodiazepines PA - Sympazan**

Drug Name(s):
SYMPAZAN

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.

Criteria for approval require ONE of the following:

A. BOTH of the following:
   i. ONE of the following:
      a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
      b. Prescriber states the patient is currently using the requested agent AND
   ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR

B. BOTH of the following:
   i. Patient has ONE of the following diagnoses:
      a. Seizure disorder OR
      b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
   ii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Biologic Immunomodulators PA - Actemra**

Drug Name(s):
ACTEMRA
ACTEMRA ACTPEN

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
            1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

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

2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Enbrel and Humira) is required for diagnoses of rheumatoid arthritis or juvenile idiopathic arthritis

NO prerequisites are required for diagnoses of giant cell arteritis or cytokine release syndrome

Prior Authorization Group – **Biologic Immunomodulators PA - Cimzia**

Drug Name(s):
CIMZIA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
            1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND

3. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Enbrel and Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnoses of psoriatic arthritis or plaque psoriasis

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

Use of TWO preferred biologics (Humira and Stelara) is required for diagnosis of Crohn's disease

NO prerequisites are required for diagnosis of non-radiographic Axial Spondyloarthritis

Prior Authorization Group – **Biologic Immunomodulators PA - Cosentyx**

Drug Name(s):
COSENTYX

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR
    D. Patient's diagnosis does NOT require a conventional agent prerequisite OR
    E. Patient's medication history indicates use of ONE formulary conventional agent prerequisite for the requested indication OR
    F. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to at least ONE formulary conventional agent for the requested indication AND
3. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

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

A. Patient is NOT currently being treated with another biologic immunomodulator OR
B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

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

NO prerequisites are required for a diagnosis of ankylosing spondylitis

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

Formulary conventional topical or systemic antipsoriatic agents include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids

Prior Authorization Group – **Biologic Immunomodulators PA - Enbrel**

Drug Name(s):
ENBREL

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR
    D. Patient's diagnosis does NOT require a conventional agent prerequisite OR
    E. Patient's medication history indicates use of ONE formulary conventional agent prerequisite for the requested indication OR
    F. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to at least ONE formulary conventional agent for the requested indication AND
3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

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

4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

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

NO prerequisites are required for a diagnosis of ankylosing spondylitis

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

Formulary conventional topical or systemic antipsoriatic agents include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids

Prior Authorization Group – **Biologic Immunomodulators PA - Humira**

Drug Name(s):
HUMIRA
HUMIRA KIT

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR
    D. Patient's diagnosis does NOT require a conventional agent prerequisite OR
    E. Patient's medication history indicates use of ONE formulary conventional agent prerequisite for the requested indication OR
    F. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to at least ONE formulary conventional agent for the requested indication AND
3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND

3. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

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

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

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

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

Formulary conventional topical or systemic antipsoriatic agents include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids

Formulary conventional agents for crohn's disease or ulcerative colitis include methotrexate

aminosalicylates, corticosteroids, cyclosporine, azathioprine, 6-mercaptopurine, metronidazole, or ciprofloxacin

Prior Authorization Group – **Biologic Immunomodulators PA - Ilumya**

Drug Name(s):
ILUMYA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
        1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) AND
3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

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

A. Patient is NOT currently being treated with another biologic immunomodulator OR
B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnosis of plaque psoriasis

Prior Authorization Group – **Biologic Immunomodulators PA - Inflectra**

Drug Name(s):
INFLECTRA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
            1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND

3. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Enbrel and Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnoses of plaque psoriasis or psoriatic arthritis

Use of TWO preferred biologics (Humira and Stelara) is required for diagnosis of adult Crohn's disease

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

Only the preferred biologic Humira is required for diagnoses of ulcerative colitis or pediatric Crohn's disease

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

Prior Authorization Group – **Biologic Immunomodulators PA - Kevzara**

Drug Name(s):
KEVZARA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) AND
3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

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

A. Patient is NOT currently being treated with another biologic immunomodulator OR

B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Use of TWO preferred biologics (Enbrel and Humira) is required for diagnosis of rheumatoid arthritis

Prior Authorization Group – **Biologic Immunomodulators PA - Kineret**

Drug Name(s):
KINERET

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
            1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

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

4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Enbrel and Humira) is required for diagnosis of rheumatoid arthritis

NO prerequisites are required for diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS)/Neonatal-Onset Multisystem Inflammatory Disease (NOMID)

Prior Authorization Group – **Biologic Immunomodulators PA - Olumiant**

Drug Name(s):
OLUMIANT

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
        1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) AND
        3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
        4. ONE of the following:
            A. Patient is NOT currently being treated with another biologic immunomodulator OR
            B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

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

A. Patient is NOT currently being treated with another biologic immunomodulator OR

B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Enbrel and Humira) is required for diagnosis of rheumatoid arthritis

Prior Authorization Group – **Biologic Immunomodulators PA - Orencia**

Drug Name(s):
ORENCIA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
        1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) AND
3. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR

B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Enbrel and Humira) is required for the diagnoses of juvenile idiopathic arthritis or rheumatoid arthritis

Use of TWO preferred biologics (Cosentyx, Humira, Enbrel or Stelara) is required for diagnosis of psoriatic arthritis

Prior Authorization Group – **Biologic Immunomodulators PA - Remicade**

Drug Name(s):
REMICADE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
            1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND

3. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Enbrel and Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnoses of plaque psoriasis or psoriatic arthritis

Use of TWO preferred biologics (Humira and Stelara) is required for diagnosis of adult Crohn's disease

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

Only the preferred biologic Humira is required for diagnoses of ulcerative colitis or pediatric Crohn's disease

No preferred biologic is required for the diagnosis of adult fistulizing Crohn's disease

Prior Authorization Group – **Biologic Immunomodulators PA - Renflexis**

Drug Name(s):
RENFLEXIS

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
            1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND
3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND

3. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Enbrel and Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnoses of plaque psoriasis or psoriatic arthritis

Use of TWO preferred biologics (Humira and Stelara) is required for diagnosis of adult Crohn's disease

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

Only the preferred biologic Humira is required for diagnoses of ulcerative colitis or pediatric Crohn's disease

No preferred biologic is required for the diagnosis of adult fistulizing Crohn's disease

Prior Authorization Group – **Biologic Immunomodulators PA - Rinvoq**

Drug Name(s):
RINVOQ

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
        C. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
        1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) AND
        3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
        4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

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

A. Patient is NOT currently being treated with another biologic immunomodulator OR

B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Only the preferred biologic Humira is required for diagnosis of rheumatoid arthritis

Prior Authorization Group – **Biologic Immunomodulators PA - Rituxan**

Drug Name(s):
RITUXAN

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.

Criteria for initial approval require ONE of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
2. ALL of the following:
    A. ONE of the following:
        i. Patient has a diagnosis of rheumatoid arthritis AND ONE of the following:
            1) Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
            2) Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) OR
        ii. Patient has another FDA labeled indication or an indication that is supported in CMS approved compendia AND
    B. Patient has been screened for hepatitis B infection measuring hepatitis B surface antigen (HBsAg) and hepatitis B core antibody (anti-HBc) and has begun therapy, if appropriate, prior to receiving the requested agent AND
    C. ONE of the following:
        i. Patient is NOT currently being treated with another biologic immunomodulator OR
        ii. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent AND

D. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Criteria for renewal approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Patient has been previously approved for the requested agent through the plan's PA criteria AND
        ii. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
        iii. ONE of the following:
            a. Patient is NOT currently being treated with another biologic immunomodulator OR
            b. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent AND
        iv. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines

Use of TWO preferred biologics (Humira and Enbrel) is required for diagnosis of rheumatoid arthritis

ALL other diagnoses do NOT require any preferred biologics

Prior Authorization Group – **Biologic Immunomodulators PA – Rituxan Hycela**

Drug Name(s):
RITUXAN HYCELA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.

Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ALL of the following:
        i. Patient has been screened for hepatitis B infection measuring hepatitis B surface antigen (HBsAg) and hepatitis B core antibody (anti-HBc) and has begun therapy, if appropriate, prior to receiving the requested agent AND
        ii. ONE of the following:
            1. Patient is NOT currently being treated with another biologic immunomodulator OR
            2. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent AND
        iii. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Criteria for renewal approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ALL of the following
        i. Patient has been previously approved for the requested agent through the plan's PA criteria AND
        ii. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
        iii. ONE of the following:
            1. Patient is NOT currently being treated with another biologic immunomodulator OR
            2. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent AND
        iv. Patient does NOT have any FDA labeled limitation(s) of use for the requested agent that is not otherwise supported in NCCN guidelines

There are no preferred biologics required for Rituxan Hycela

Prior Authorization Group – **Biologic Immunomodulators PA - Siliq**

Drug Name(s):
SILIQ

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
        1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) AND
        3. ONE of the following:
            A. Patient is NOT currently being treated with another biologic immunomodulator OR
            B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR

B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnosis of plaque psoriasis

Prior Authorization Group – **Biologic Immunomodulators PA - Simponi**

Drug Name(s):
SIMPONI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) AND
3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

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

A. Patient is NOT currently being treated with another biologic immunomodulator OR
B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Enbrel and Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnosis of psoriatic arthritis

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

Only the preferred biologic Humira is required for diagnosis of ulcerative colitis

Prior Authorization Group – **Biologic Immunomodulators PA - Simponi Aria**

Drug Name(s):
SIMPONI ARIA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
        1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) AND
3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

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

A. Patient is NOT currently being treated with another biologic immunomodulator OR
B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Enbrel and Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnosis of psoriatic arthritis

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

Prior Authorization Group – **Biologic Immunomodulators PA - Skyrizi**

Drug Name(s):
SKYRIZI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
        1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) AND
        3. ONE of the following:
            A. Patient is NOT currently being treated with another biologic immunomodulator OR
            B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR

B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnosis of plaque psoriasis

Prior Authorization Group – **Biologic Immunomodulators PA - Stelara**

Drug Name(s):
STELARA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR
    D. Patient's medication history indicates use of ONE formulary conventional agent prerequisite for the requested indication OR
    E. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to at least ONE formulary conventional agent for the requested indication AND
3. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR

B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of ONE conventional agent prerequisite is required for diagnoses of psoriatic arthritis, plaque psoriasis, or Crohn's disease

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

Formulary conventional topical or systemic antipsoriatic agents include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids

Formulary conventional agents for Crohn's disease include methotrexate aminosalicylates, corticosteroids, cyclosporine, azathioprine, 6-mercaptopurine, metronidazole, or ciprofloxacin

Prior Authorization Group – **Biologic Immunomodulators PA - Taltz**

Drug Name(s):
TALTZ

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
        1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) AND
3. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR

B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnoses of psoriatic arthritis or plaque psoriasis

Prior Authorization Group – **Biologic Immunomodulators PA - Tremfya**

Drug Name(s):
TREMFYA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
        1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) AND
3. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has shown clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR

B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnosis of plaque psoriasis

Prior Authorization Group – **Biologic Immunomodulators PA - Xeljanz**

Drug Name(s):
XELJANZ
XELJANZ XR

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND is at risk if therapy is changed OR
    C. Patient's diagnosis is indicated in preferred biologic immunomodulator agent(s) AND ONE of the following:
        1. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to preferred biologic immunomodulator agent(s) AND
3. Patient has been tested for latent TB AND if positive the patient has begun therapy for latent TB AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another biologic immunomodulator OR
    B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

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

A. Patient is NOT currently being treated with another biologic immunomodulator OR
B. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
For Xeljanz:
Use of TWO preferred biologics (Enbrel and Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnosis of psoriatic arthritis

Only the preferred biologic Humira is required for diagnosis Ulcerative colitis

For Xeljanz XR:
Use of TWO preferred biologics (Enbrel and Humira) is required for diagnosis of rheumatoid arthritis

Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnosis of psoriatic arthritis

Prior Authorization Group – **Bivigam/Flebogamma/Gammaplex/Octagam/Privigen PA**

Drug Name(s):
BIVIGAM
FLEBOGAMMA
GAMMAPLEX
OCTAGAM
PRIVIGEN

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has ONE of the following diagnoses:
    A. Primary immunodeficiency (including congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency) OR
    B. Chronic lymphocytic leukemia OR multiple myeloma with reduced IgG AND ONE of the following:
        i. Patient has a history of infections OR
        ii. Patient has evidence of specific antibody deficiency OR
    C. Idiopathic thrombocytopenia purpura AND ONE of the following:
        i. Patient has failed ONE conventional therapy (e.g. corticosteroids (e.g. methylprednisolone), or immunosuppressants (e.g. azathioprine)) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    D. Dermatomyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy (e.g. corticosteroids (e.g. methylprednisolone) or immunosuppressants (e.g. azathioprine)) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    E. Polymyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy (e.g. corticosteroids (e.g. methylprednisolone) or immunosuppressants (e.g. azathioprine)) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

F. Severe rheumatoid arthritis AND ONE of the following:
i. Patient has failed ONE conventional therapy (e.g. tumor necrosis factor antagonists (e.g. Humira), DMARDS (e.g. methotrexate), Renflexis) OR
ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

Criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 3 months for indications in NHS guidelines, 12 months all others

Other Criteria:
G. Myasthenia gravis (MG) AND ONE of the following:
i. Patient is in acute myasthenic crisis with decompensation (e.g. acute episode of respiratory muscle weakness, respiratory failure, dysphagia, major functional disability responsible for the discontinuation of physical activity) OR
ii. Patient has severe refractory MG (e.g. major functional disability/weakness) AND ONE of the following:
a) Patient has failed ONE immunomodulator therapy (i.e. corticosteroid, pyridostigmine, or azathioprine) OR
b) Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE immunomodulator therapy OR

H. Multiple sclerosis (MS) AND BOTH of the following:
i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND
ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication(s) to TWO MS agents (e.g. Aubagio, Avonex, Betaseron, glatiramer (i.e. Copaxone, Glatopa), Plegridy, Tecfidera or Tysabri) OR

I. Acquired von Willebrand hemophilia AND ONE of the following:
i. Patient has failed ONE conventional therapy (e.g. desmopressin solution, von Willebrand factor replacement therapy, corticosteroids, cyclophosphamide, FEIBA, Rituxan, or recombinant factor VIIa) OR
ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

J. Refractory pemphigus vulgaris AND ONE of the following:

i. Patient has failed ONE conventional immunosuppressive therapy (e.g. azathioprine, cyclophosphamide, mycophenolate, corticosteroids) OR
ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional immunosuppressive therapy OR

2. ONE of the following:
A. Patient has another FDA labeled indication for the requested agent OR
B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Indications with 3 month approval duration:
Idiopathic thrombocytopenia purpura, Acquired von Willebrand hemophilia, Guillain-Barre Syndrome, Lambert-Eaton myasthenia syndrome, Myasthenia gravis, Kawasaki disease, CMV induced pneumonitis in solid organ transplant, Toxic shock syndrome due to invasive group A streptococcal, Toxic epidermal necrolysis and Steven Johnsons syndrome

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

Prior Authorization Group – **Botulinum Toxin PA - Botox**

Drug Name(s):
BOTOX

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
Used for cosmetic purposes AND FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require the following:
1. Patient has ONE of the following diagnoses:
    A. Blepharospasm associated with dystonia (including benign essential blepharospasm or VII nerve disorders) OR
    B. Cervical dystonia AND the requested agent will be used to reduce the severity of abnormal head position and neck pain OR
    C. Axillary hyperhidrosis OR
    D. Chronic migraine AND ONE of the following:
        i. Patient has tried and failed at least TWO conventional prophylaxis prerequisite agents from TWO different classes (e.g. beta blockers [propranolol], anticonvulsants [divalproex, topiramate]) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to TWO conventional prophylaxis prerequisite agents from TWO different classes OR
    E. Neurogenic bladder with detrusor muscle overactivity AND ONE of the following:
        i. Patient has tried and failed TWO urinary anticholinergic agents (e.g. oxybutynin, tolterodine) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a urinary anticholinergic agent OR
    F. Strabismus OR
    G. Upper limb spasticity AND BOTH of the following:
        i. Patient has increased muscle tone in one or more of the following muscle groups: elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris), finger flexors (flexor digitorum profundus and flexor digitorum sublimis), or thumb flexors (adductor pollicis and flexor pollicis longus) AND
        ii. ONE of the following:

1. Patient has tried and failed tizanidine and diazepam OR
2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to tizanidine and diazepam OR

Initial criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

H. Overactive Bladder AND ONE of the following:
i. Patient has tried and failed TWO urinary anticholinergic agents (e.g. oxybutynin, tolterodine) OR
ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a urinary anticholinergic agent OR

I. Lower limb spasticity AND ONE of the following:
i. Patient has increased muscle tone in ankle and/or toe flexors AND
ii. ONE of the following:
1. Patient has tried and failed tizanidine and diazepam OR
2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to tizanidine and diazepam OR

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

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. ONE of the following:
a. Patient has an FDA labeled indication for the requested agent OR
b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
3. Patient has shown clinical benefit with the requested agent

Prior Authorization Group – **Botulinum Toxin PA - Dysport**

Drug Name(s):
DYSPORT

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
Used for cosmetic purposes AND FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require the following:
1. Patient has ONE of the following diagnoses:
    A. Cervical dystonia OR
    B. Upper or Lower limb spasticity AND ONE of the following:
        i. Patient has tried and failed tizanidine and diazepam OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to tizanidine and diazepam OR
    C. Patient has an indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
3. Patient has shown clinical benefit with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Botulinum Toxin PA - Xeomin**

Drug Name(s):
XEOMIN

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
Used for cosmetic purposes AND FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require the following:
1. Patient has ONE of the following diagnoses:
    A. Blepharospasm associated with dystonia AND the patient was previously treated with onabotulinumtoxinA (Botox) OR
    B. Cervical dystonia OR
    C. Upper limb spasticity AND ONE of the following:
        i. Patient has tried and failed tizanidine and diazepam OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to tizanidine and diazepam OR
    D. Chronic Sialorrhea OR
    E. Patient has an indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
3. Patient has shown clinical benefit with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Carbaglu PA**

Drug Name(s):
CARBAGLU

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of ONE of the following:
    a. Acute hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) OR
    b. Chronic hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) AND
2. The dose requested is within the FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. geneticist, metabolic disorders) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Carimune PA**

Drug Name(s):
CARIMUNE NF

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has ONE of the following diagnoses:
    A. Primary immunodeficiency (including congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency) OR
    B. Chronic lymphocytic leukemia OR multiple myeloma with reduced IgG AND ONE of the following:
        i. Patient has a history of infections OR
        ii. Patient has evidence of specific antibody deficiency OR
    C. Idiopathic thrombocytopenia purpura AND ONE of the following:
        i. Patient has failed ONE conventional therapy (e.g. corticosteroids (e.g. methylprednisolone), or immunosuppressants (e.g. azathioprine)) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    D. Dermatomyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy (e.g. corticosteroids (e.g. methylprednisolone) or immunosuppressants (e.g. azathioprine)) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    E. Polymyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy (e.g. corticosteroids (e.g. methylprednisolone) or immunosuppressants (e.g. azathioprine)) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    F. Severe rheumatoid arthritis AND ONE of the following:
        i. Patient has failed ONE conventional therapy (e.g. tumor necrosis factor antagonists (e.g. Humira), DMARDS (e.g. methotrexate), Renflexis) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

Criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 3 months for indications in NHS guidelines, 12 months all others

Other Criteria:
G. Myasthenia gravis (MG) AND ONE of the following:
i. Patient is in acute myasthenic crisis with decompensation (e.g. acute episode of respiratory muscle weakness, respiratory failure, dysphagia, major functional disability responsible for the discontinuation of physical activity) OR
ii. Patient has severe refractory MG (e.g. major functional disability/weakness) AND ONE of the following:
a) Patient has failed ONE immunomodulator therapy (i.e. corticosteroid, pyridostigmine, or azathioprine) OR
b) Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE immunomodulator therapy OR

H. Multiple sclerosis (MS) AND BOTH of the following:
i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND
ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication(s) to TWO MS agents (e.g. Aubagio, Avonex, Betaseron, glatiramer (i.e. Copaxone, Glatopa), Plegridy, Tecfidera or Tysabri) OR

I. Acquired von Willebrand hemophilia AND ONE of the following:
i. Patient has failed ONE conventional therapy (e.g. desmopressin solution, von Willebrand factor replacement therapy, corticosteroids, cyclophosphamide, FEIBA, Rituxan, or recombinant factor VIIa) OR
ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

J. Refractory pemphigus vulgaris AND ONE of the following:
i. Patient has failed ONE conventional immunosuppressive therapy (e.g. azathioprine, cyclophosphamide, mycophenolate, corticosteroids) OR
ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional immunosuppressive therapy OR

2. ONE of the following:
A. Patient has another FDA labeled indication for the requested agent OR

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

Indications with 3 month approval duration:
Idiopathic thrombocytopenia purpura, Acquired von Willebrand hemophilia, Guillain-Barre Syndrome, Lambert-Eaton myasthenia syndrome, Myasthenia gravis, Kawasaki disease, CMV induced pneumonitis in solid organ transplant, Toxic shock syndrome due to invasive group A streptococcal, Toxic epidermal necrolysis and Steven Johnsons syndrome

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

Prior Authorization Group – **Chenodal PA**

Drug Name(s):
CHENODAL

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of radiolucent stones in a well-opacifying gallbladder AND
2. The dose requested is within FDA labeled dosing

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Chorionic Gonadotropin PA**

Drug Name(s):
CHORIONIC GONADOTROPIN
NOVAREL
PREGNYL

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
Used to promote fertility or to treat erectile dysfunction AND FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ONE of the following:
A. Patient has a diagnosis of prepubertal cryptorchidism not due to anatomic obstruction OR
B. Patient is a male with a diagnosis of hypogonadotropic hypogonadism (hypogonadism secondary to pituitary deficiency) AND BOTH of the following:
    i. Patient has a measured current or pretreatment total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR a free serum testosterone level that is below the testing laboratory's lower limit of the normal range AND
    ii. Patient has measured luteinizing hormone (LH) AND follicle-stimulating hormone (FSH) levels that are at (low-normal) or below the testing laboratory's normal range OR
C. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Cinacalcet PA**

Drug Name(s):
cinacalcet tablet
SENSIPAR

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require the following:
1. Patient has ONE of the following:
    A. An FDA approved indication or has an indication that is supported in CMS approved compendia for the requested agent not otherwise excluded from Part D [i.e., secondary hyperparathyroidism due to end-stage renal disease (ESRD) on dialysis] AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently using the requested agent AND is at risk if therapy is changed OR
    B. A diagnosis of hypercalcemia due to parathyroid carcinoma OR
    C. A diagnosis of primary hyperparathyroidism (HPT) AND BOTH of the following:
        i. Patient has a pretreatment serum calcium that is above the testing laboratory's upper limit of normal AND
        ii. Patient is unable to undergo parathyroidectomy OR
    D. Another indication that is supported in CMS approved compendia for the requested agent not otherwise excluded from Part D

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Corlanor PA**

Drug Name(s):
CORLANOR

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has stable, symptomatic chronic heart failure (e.g. NYHA Class II, III, IV, ACCF/AHA Class C, D) AND
2. ONE of the following:
    a. ALL of the following:
        i. The requested agent is for a pediatric patient, 6 months or over AND
        ii. Patient has heart failure due to dilated cardiomyopathy (DCM) AND
        iii. Patient is in sinus rhythm with an elevated heart rate OR
    b. ALL of the following:
        i. The requested agent is for an adult patient AND
        ii. Patient has a baseline OR current left ventricular ejection fraction of 35% or less AND
        iii. Patient is in sinus rhythm with a resting heart rate of 70 beats or greater per minute prior to initiating therapy with the requested agent AND
        iv. ONE of the following:
            1. Patient is on a maximally tolerated dose of beta blocker (e.g. atenolol, bisoprolol, carvedilol, metoprolol) OR
    2. Patient has a history of a documented intolerance, FDA labeled contraindication, or hypersensitivity to a beta blocker

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Cresemba PA**

Drug Name(s):
CRESEMBA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ONE of the following:
1. Patient has a diagnosis of invasive aspergillosis OR
2. Patient has a diagnosis of invasive mucormycosis OR
3. Patient has another indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of invasive aspergillosis and the patient has continued indicators of active disease (e.g. continued radiologic findings, direct microscopy findings, histopathology findings, positive cultures, positive serum galactomannan assay) OR
    B. Patient has a diagnosis of invasive mucormycosis and the patient has continued indicators of active disease (e.g. continued radiologic findings, direct microscopy findings, histopathology findings, positive cultures, positive serum galactomannan assay) OR
    C. Patient has another indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 6 months

Other Criteria:

Prior Authorization Group – **Crinone PA**

Drug Name(s):
CRINONE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
Requested agent will be used to treat infertility AND FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has an FDA labeled indication for the requested agent OR
2. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Crysvita PA**

Drug Name(s):
CRYSVITA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of X-linked hypophosphatemia (XLH) as confirmed by testing for renal phosphate wasting AND radiography AND
2. ONE of the following:
    a. Patient's epiphyseal plate has not fused OR
    b. Patient's epiphyseal plate has fused AND the patient is experiencing symptoms of XLH (e.g. bone pain, fractures, limited mobility) AND
3. The dose requested is within the FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's prior authorization criteria AND
2. Patient has a diagnosis of X-linked hypophosphatemia (XLH) AND
3. Patient has had clinical improvement with the requested agent (e.g. enhanced height velocity, improvement in lower extremity bowing and associated abnormalities, radiographic evidence of epiphyseal healing, improvement in bone pain, enhanced mobility, improvement in osteomalacia, and improvement in fracture healing) AND
4. The dose requested is within the FDA labeled dosing for the requested indication

Age Restrictions:
Patient is 1 year of age or older

Prescriber Restrictions:
Prescriber is a specialist (e.g. nephrologist, endocrinologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Cutaquig PA**

Drug Name(s):
CUTAQUIG

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has ONE of the following diagnoses:
    A. Primary immunodeficiency [including congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency] OR
    B. Multiple sclerosis (MS) AND BOTH of the following:
        i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND
        ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication(s) to TWO MS agents (e.g. Aubagio, Avonex, Betaseron, glatiramer (i.e. Copaxone, Glatopa), Plegridy, Tecfidera or Tysabri) OR
2. ONE of the following:
    A. Patient has another FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Cystinosis Agents PA - Cystagon**

Drug Name(s):
CYSTAGON

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of nephropathic cystinosis AND
2. Prescriber has performed a baseline white blood cell (WBC) cystine level test AND
3. The dose requested is within the FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of nephropathic cystinosis AND
3. Patient has had clinical improvement (e.g. decrease in WBC cystine levels from baseline) with the requested agent AND
4. The dose requested is within the FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Cystinosis Agents PA - Procysbi**

Drug Name(s):
PROCYSBI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of nephropathic cystinosis AND
2. Prescriber has performed a baseline white blood cell (WBC) cystine level test AND
3. The dose requested is within the FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of nephropathic cystinosis AND
3. Patient has had clinical improvement (e.g. decrease in WBC cystine levels from baseline) with the requested agent AND
4. The dose requested is within the FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Daklinza PA**

Drug Name(s):
DAKLINZA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of chronic hepatitis C infection confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The dosing of the requested agent is within the FDA labeled dosing or is AASLD/IDSA guideline supported AND
5. ONE of the following:
    A. There is documentation that the patient is currently being treated with the requested agent OR
    B. Patient has an FDA labeled contraindication or hypersensitivity to the preferred agents: Harvoni (ledipasvir/sofosbuvir) for supported genotypes OR Epclusa (sofosbuvir/velpatasvir) for genotype 2 or 3 OR
    C. Prescriber has submitted documentation based on FDA approved labeling or AASLD/IDSA guidelines to support the use of the non-preferred agent for the patient's diagnosis and genotype over the preferred agents: Harvoni (ledipasvir/sofosbuvir) for supported genotypes OR Epclusa (sofosbuvir/velpatasvir) for genotype 2 or 3

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist

Coverage Duration:

Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported

Other Criteria:

Prior Authorization Group – **Dalfampridine PA**

Drug Name(s):
AMPYRA
dalfampridine ER tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of multiple sclerosis (MS) AND
2. If the patient has relapsing form of MS, ONE of the following:
    A. There is evidence of a claim that the patient is receiving concurrent therapy within the past 30 days with a disease modifying agent (e.g. Aubagio, Avonex, Betaseron, Extavia, Gilenya, glatiramer (i.e. Copaxone, Glatopa), Lemtrada, mitoxantrone, Plegridy, Rebif, Tecfidera, or Tysabri) OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a disease modifying agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of multiple sclerosis (MS) AND
3. Patient has demonstrated a stabilization or improvement from baseline in timed walking speed (timed 25 foot walk)

Age Restrictions:

Prescriber Restrictions:
Prescriber is a neurologist or the prescriber has consulted with a neurologist

Coverage Duration:
Initial approval 3 months. 12 months for renewal.

Other Criteria:

Prior Authorization Group – **Daliresp PA**

Drug Name(s):
DALIRESP

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of following:
    a. Patient has had an inadequate response to an agent from two of the following categories:
        i. long-acting beta-2 agonist (LABA) [e.g. salmeterol]
        ii. long-acting antimuscarinic antagonist/anticholinergic (LAMA) [e.g. tiotropium]
        iii. inhaled corticosteroid (ICS) [e.g. fluticasone] OR
    b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to an agent from two of the following categories:
        i. long-acting beta-2 agonist (LABA) [e.g. salmeterol]
        ii. long-acting antimuscarinic antagonist/anticholinergic (LAMA) [e.g. tiotropium]
        iii. inhaled corticosteroid (ICS) [e.g. fluticasone]

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Doptelet PA**

Drug Name(s):
DOPTELET

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ONE of the following:
1. Patent has a diagnosis of thrombocytopenia AND ALL of following:
    A. Patient has chronic liver disease AND
    B. Patient has a platelet count less than 50 X 109/L AND
    C. Patient is scheduled to undergo a procedure with an associated risk of bleeding (e.g. gastrointestinal endoscopy, liver biopsy, bronchoscopy, dental procedure) AND
    D. The dosing of the requested agent is within the FDA labeled dosing AND
    E. The length of therapy of the requested agent is within the FDA labeled duration OR
2. Patient has a diagnosis of chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following:
    A. Patient has had an insufficient response to corticosteroids or immunoglobulins (IVIg or anti-D) or another thrombopoietin receptor agonist (e.g., Nplate, Promacta) OR
    B. Patient has had an insufficient response to a splenectomy OR
    C. BOTH of the following:
        i. Patient is NOT a candidate for splenectomy AND
        ii. Patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to corticosteroids, immunoglobulins (IVIg or anti-D), or another thrombopoietin receptor agonist (e.g., Nplate, Promacta)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Initial 6 months for ITP, Renewal 12 months for ITP. Initial & Renewal 1 month for other indication

Other Criteria:

Criteria for renewal approval require BOTH of the following:

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

2. ONE of following:

A. Patent has a diagnosis of thrombocytopenia AND ALL of following:

i. Patient has chronic liver disease AND

ii. Patient has a platelet count less than 50 X 109/L AND

iii. Patient is scheduled to undergo a procedure with an associated risk of bleeding (e.g. gastrointestinal endoscopy, liver biopsy, bronchoscopy, dental procedure) AND

iv. The dosing of the requested agent is within the FDA labeled dosing AND

v. The length of therapy of the requested agent is within the FDA labeled duration OR

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

i. Patient's platelet count is 50 x 109/L or greater OR

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

Prior Authorization Group – **Dupixent PA**

Drug Name(s):
DUPIXENT

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of moderate-to-severe atopic dermatitis AND BOTH of the following:
        i. ONE of the following:
            a. Patient has tried and failed a topical steroid (e.g. clobetasol, triamcinolone) OR
            b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a topical steroid AND
        ii. ONE of the following:
            a. Patient has tried and failed a topical calcineurin inhibitor (e.g. pimecrolimus) OR
            b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a topical calcineurin inhibitor OR

Criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. dermatologist, allergist, immunologist, otolaryngologist, pulmonologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:
    B. Patient has a diagnosis of moderate-to-severe asthma AND ALL of the following:
        i. Patient is 12 years of age or over AND
        ii. ONE of the following:

a. Patient has an eosinophilic phenotype AND the patient has a baseline blood eosinophil count of 150 cells/microliter or higher OR

b. Patient has oral corticosteroid dependent asthma AND

iii. Patient has a baseline Forced Expiratory Volume (FEV1) that is less than 80% of predicted AND

iv. ONE of the following:

a. BOTH of the following:

1. Patient is NOT currently being treated with the requested agent AND

2. Patient is currently being treated with a maximally tolerated inhaled corticosteroid within the past 90 days OR

b. BOTH of the following:

1. Patient is currently being treated with the requested agent AND

2. Patient is also currently being treated with an inhaled corticosteroid that is dosed as needed to control symptoms OR

c. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to an inhaled corticosteroid AND

v. ONE of the following:

a. There is evidence of a claim within the past 90 days that the patient is currently being treated with ONE of the following:

1. A long-acting beta-2 agonist (LABA) OR

2. A leukotriene receptor antagonist (LRTA) OR

3. A long-acting muscarinic antagonist (LAMA) OR

4. Theophylline OR

b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a long-acting beta-2 agonist (LABA), leukotriene receptor antagonist (LRTA), long-acting muscarinic antagonist (LAMA), OR theophylline AND

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

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

i. Patient is 18 years of age or over AND

ii. Patient's diagnosis was confirmed by ONE of the following:

a. Anterior rhinoscopy or endoscopy OR

b. Computed tomography (CT) of the sinuses AND

iii. ONE of the following:

a. Patient has tried and had an inadequate response to an oral systemic corticosteroid OR

b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to an oral systemic corticosteroid AND

iv. ONE of the following:

a. Patient has tried and had an inadequate response to an intranasal corticosteroid (e.g., fluticasone) OR

b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to an intranasal corticosteroid AND

v. Patient will continue standard maintenance therapy (e.g., intranasal corticosteroids) in combination with the requested agent AND

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

Prior Authorization Group – **Egrifta PA**

Drug Name(s):
EGRIFTA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of HIV infection AND
2. The requested agent will be used to reduce excess abdominal fat in an HIV-infected patient with lipodystrophy AND
3. Patient is currently on anti-retroviral therapy (ART) within the past 90 days AND
4. Prescriber has measured baseline visceral adipose tissue (VAT) and waist circumference AND
5. Patient is NOT planning to become pregnant or currently breastfeeding

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. The requested agent will be used to reduce excess abdominal fat in an HIV-infected patient with lipodystrophy AND
3. Patient is currently on anti-retroviral therapy (ART) within the past 90 days AND
4. Patient has achieved or maintained a decrease in visceral adipose tissue (VAT) from baseline OR maintained or decreased waist circumference from baseline AND
5. Patient is NOT planning to become pregnant or currently breastfeeding

Age Restrictions:
Patient is between 18 and 65 years of age

Prescriber Restrictions:

Coverage Duration:
Initial approval 6 months. Renewal approval 12 months.

Other Criteria:

Prior Authorization Group – **Emflaza PA**

Drug Name(s):
EMFLAZA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) confirmed by ONE of the following:
    A. Presence of abnormal dystrophin OR
    B. Confirmed mutation of the dystrophin gene AND
2. The dose requested is within the FDA labeled dosing

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) AND
3. Patient has had improvement, stabilization of the disease, or clinical benefit from baseline (e.g. improved strength and timed motor function, improved pulmonary function, reduced the need for scoliosis surgery) AND
4. The dose requested is within the FDA labeled dosing

Age Restrictions:
Patient is 2 years of age or over

Prescriber Restrictions:
Prescriber is a specialist (e.g. neurologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Emgality PA**

Drug Name(s):
EMGALITY

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of migraine AND BOTH of the following:
        i. Patient has 4 migraine headaches or more per month AND
        ii. ONE of the following:
            A. Patient has failed at least TWO conventional migraine prophylaxis agents from TWO different classes (e.g. beta blockers [propranolol], anticonvulsants [divalproex, topiramate]) OR
            B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to TWO conventional migraine prophylaxis agents from TWO different classes OR
    b. Patient has a diagnosis of episodic cluster headache AND BOTH of the following:
        i. Patient has had at least 5 cluster headache attacks AND
        ii. Patient has had at least two cluster periods lasting 7 days to one year and separated by pain-free remission periods of 3 months or more AND
2. ONE of the following:
    a. Patient is NOT currently taking another calcitonin gene-related peptide (CGRP) agent OR
    b. Patient is currently being treated with another calcitonin gene-related peptide (CGRP) agent AND will discontinue prior to initiating therapy with the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's prior authorization criteria AND
2. ONE of the following:
    a. Patient has a diagnosis of migraine OR
    b. Patient has a diagnosis of episodic cluster headache AND
3. Patient has shown clinical benefit with the requested agent AND
4. ONE of the following:

a. Patient is NOT currently taking another calcitonin gene-related peptide (CGRP) agent OR
b. Patient is currently being treated with another calcitonin gene-related peptide (CGRP) agent AND will discontinue prior to continuing therapy with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Epclusa PA**

Drug Name(s):
EPCLUSA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The dosing of the requested agent is within the FDA labeled dosing or is AASLD/IDSA guideline supported AND
5. ONE of the following:
    A. There is documentation that the patient is currently being treated with the requested agent OR
    B. Patient has an FDA labeled contraindication or hypersensitivity to the preferred agent: Harvoni (ledipasvir/sofosbuvir) for supported genotypes OR
    C. Prescriber has submitted documentation based on FDA approved labeling or AASLD/IDSA guidelines to support the use of the non-preferred agent for the patient's diagnosis and genotype over the preferred agent: Harvoni (ledipasvir/sofosbuvir) for supported genotypes

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist

Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported

Other Criteria:

Prior Authorization Group – **Epidiolex PA**

Drug Name(s):
EPIDIOLEX

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
This program applies to new starts only.
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of Lennox-Gastaut syndrome OR
    b. Patient has a diagnosis of Dravet syndrome AND
2. The dose requested is within the FDA labeled dosing for the requested indication

Age Restrictions:
Patient is 2 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Erythropoietin Stimulating Agents PA - Aranesp**

Drug Name(s):
ARANESP

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. The requested agent is being prescribed for ONE of the following:
    A. Anemia due to myelosuppressive chemotherapy for a non-myeloid malignancy AND ALL of the following:
        i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR less than 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND
        ii. Patient is being concurrently treated with chemotherapy, with or without radiation (treatment period extends to 8 weeks post chemotherapy) AND
        iii. Intent of chemotherapy is non-curative OR
    B. Anemia associated with chronic renal failure in a patient NOT on dialysis AND ALL of the following:
        i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR 11 g/dL or less for patients stabilized on therapy (measured within the previous 4 weeks) AND
        ii. Rate of hemoglobin decline indicates the likelihood of requiring a RBC transfusion AND
        iii. Intent of therapy is to reduce risk of alloimmunization and/or other RBC transfusion related risks OR
    C. Anemia due to myelodysplastic syndrome AND patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) OR
    D. Another indication that is supported in CMS approved compendia for the requested agent AND patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND
2. Patient's transferrin saturation and serum ferritin have been evaluated

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
6 months for chemotherapy, 12 months for other indications

Other Criteria:

Prior Authorization Group – **Erythropoietin Stimulating Agents PA-Epogen/Procrit**

Drug Name(s):
EPOGEN
PROCRIT

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of:
1. Requested agent is being prescribed for ONE of:
    A. To reduce the possibility of allogeneic blood transfusion in surgery patient (pt) AND pt's hemoglobin level is greater than 10 g/dL but 13 g/dL or less OR
    B. Anemia due to myelosuppressive chemotherapy for a non-myeloid malignancy AND ALL of:
        i. Pt's hemoglobin level is less than 10 g/dL for pts initiating ESA therapy OR less than 12 g/dL for pts stabilized on therapy (measured within the previous 4 weeks) AND
        ii. Pt is being concurrently treated with chemotherapy with or without radiation (treatment period extends to 8 weeks post chemotherapy) AND
        iii. Intent of chemotherapy is non-curative OR
    C. Anemia associated with chronic renal failure in a pt NOT on dialysis AND ALL of:
        i. Pt's hemoglobin level is less than 10 g/dL for pts initiating ESA therapy OR 11 g/dL or less for pts stabilized on therapy (measured within the previous 4 weeks) AND
        ii. Rate of hemoglobin decline indicates the likelihood of requiring a RBC transfusion AND
        iii. Intent of therapy is to reduce the risk of alloimmunization and/or other RBC transfusion related risks OR
    D. Anemia due to myelodysplastic syndrome AND pt's hemoglobin level is less than 12 g/dL for pts initiating ESA therapy OR less than or equal to 12 g/dL for pts stabilized on therapy (measured within previous 4 weeks) OR
    E. Anemia resulting from zidovudine treatment of HIV infection AND pt's hemoglobin level is less than 12 g/dL for pts initiating ESA therapy OR less than or equal to 12 g/dL for pts stabilized on therapy (measured within previous 4 weeks) OR

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

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

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

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

Other Criteria:

Prior Authorization Group – **Erythropoietin Stimulating Agents PA - Mircera**

Drug Name(s):
MIRCERA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. The requested agent is being prescribed for ONE of the following:
    A. Anemia associated with chronic renal failure in a patient NOT on dialysis AND ALL of the following:
        i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR 11 g/dL or less for patients stabilized on therapy (measured within the previous 4 weeks) AND
        ii. Rate of hemoglobin decline indicates the likelihood of requiring a RBC transfusion AND
        iii. Intent of therapy is to reduce the risk of alloimmunization and/or other RBC transfusion related risks OR
    B. Another indication that is supported in CMS approved compendia for the requested agent AND patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND
2. Patient's transferrin saturation and serum ferritin have been evaluated

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Erythropoietin Stimulating Agents PA - Retacrit**

Drug Name(s):
RETACRIT

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. The requested agent is being prescribed for ONE of the following:
    A. To reduce the possibility of allogeneic blood transfusion in a surgery patient AND the patient's hemoglobin level is greater than 10 g/dL but 13 g/dL or less OR
    B. Anemia due to myelosuppressive chemotherapy for a non-myeloid malignancy AND ALL of the following:
        i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR less than 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND
        ii. Patient is being concurrently treated with chemotherapy with or without radiation (treatment period extends to 8 weeks post chemotherapy) AND
        iii. The intent of chemotherapy is non-curative OR
    C. Anemia associated with chronic renal failure in a patient NOT on dialysis AND ALL of the following:
        i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR 11 g/dL or less for patients stabilized on therapy (measured within the previous 4 weeks) AND
        ii. The rate of hemoglobin decline indicates the likelihood of requiring a RBC transfusion AND
        iii. The intent of therapy is to reduce the risk of alloimmunization and/or other RBC transfusion related risks OR
    D. Anemia resulting from zidovudine treatment of HIV infection AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR 12 g/dL or less for patients stabilized on therapy (measured within the previous 4 weeks) OR
    E. Another indication that is supported in CMS approved compendia for the requested agent AND the patient's hemoglobin level is less than 12 g/dL for

patients initiating ESA therapy OR 12 g/dL or less for patients stabilized on therapy (measured within the previous 4 weeks) AND

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

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

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

Other Criteria:

Prior Authorization Group – **Evenity PA**

Drug Name(s):
EVENITY

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require ALL of the following:
1. Patient is a postmenopausal female with a diagnosis of osteoporosis defined as ONE of the following:
    a. Patient has a history of vertebral fracture(s), or low trauma or fragility fracture(s) [e.g., prior fracture from minor trauma such as falling from standing height or less] within the past 5 years OR
    b. Patient has a T-score that is -2.5 or lower AND ONE of the following:
        i. Patient has failed either a bisphosphonate or selective estrogen receptor modulator (SERM) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate or SERM AND
2. ONE of the following:
    a. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR
    b. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR
    c. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) AND
3. ONE of the following:
    a. Patient is not receiving concomitant Forteo (teriparatide), Prolia (denosumab), Tymlos (abaloparatide), Xgeva (denosumab), bisphosphonate, or SERM therapy within the past 90 days OR
    b. Patient will discontinue the current Forteo (teriparatide), Prolia (denosumab), Tymlos (abaloparatide), Xgeva (denosumab), bisphosphonate, or SERM therapy prior to initiating therapy with the requested agent AND
4. The dose requested is within the FDA labeled dosing for the requested indication AND
5. The total cumulative duration of treatment with Evenity (romosozumab-aqqg) has not exceeded 12 months

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
No prior use approve 12 months, Prior use approve remainder of 12 months of total cumulative therapy

Other Criteria:

Prior Authorization Group – **Exondys 51 PA**

Drug Name(s):
EXONDYS 51

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 51 skipping AND
2. The dose requested is within the FDA labeled dosing

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) AND
3. Patient has had improvement, stabilization of the disease, or clinical benefit from baseline AND
4. The dose requested is within the FDA labeled dosing

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. neurologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Fasenra PA**

Drug Name(s):
FASENRA
FASENRA PEN

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of severe eosinophilic asthma AND
2. Patient's diagnosis has been confirmed by blood eosinophilic count greater than or equal to 150 cells/microliter AND
3. ONE of the following:
    i. Patient is aged 12 years to 17 years AND patient has a baseline Forced Expiratory Volume (FEV1) that is less than 90% of predicted OR
    ii. Patient is aged 18 years or over AND patient has a baseline Forced Expiratory Volume (FEV1) that is less than 80% of predicted AND
4. Patient has ONE of the following:
    i. Frequent severe asthma exacerbations requiring two or more courses of systemic corticosteroids (steroid burst) within the past 12 months OR
    ii. Serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within the past 12 months OR
    iii. Controlled asthma that worsens when the doses of inhaled or systemic corticosteroids are tapered AND
5. ONE of the following:
    i. There is evidence of a claim within the past 90 days that the patient is currently being treated with a maximally tolerated inhaled corticosteroid OR
    ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to inhaled corticosteroid AND
6. ONE of the following:
    i. There is evidence of a claim within the past 90 days that the patient is currently being treated with ONE of the following:
        1. A long-acting beta-2 agonist (LABA) OR
        2. A leukotriene receptor antagonist (LRTA) OR
        3. Long-acting muscarinic antagonist (LAMA) OR
        4. Theophylline OR
    ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a long-acting beta-2 agonist (LABA), leukotriene receptor

antagonist (LRTA), long-acting muscarinic antagonist (LAMA), or theophylline AND

Initial criteria continues: see Other Criteria

Age Restrictions:
Patient is 12 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
7. Patient will NOT receive the requested agent in combination with Xolair or with another interleukin 5 (IL-5) inhibitor for the requested indication (e.g. Cinqair, Nucala) AND
8. The dose requested is within the FDA labeled dosing

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of severe eosinophilic asthma AND
3. Patient has had clinical response or disease stabilization as defined by ONE of the following:
    i. Increase in percent predicated Forced Expiratory Volume (FEV1) from baseline OR
    ii. Decrease in the dose of inhaled corticosteroids required to control the patient's asthma OR
    iii. Decrease in need for treatment with systemic corticosteroids due to exacerbations of asthma OR
    iv. Decrease in number of hospitalizations, need for mechanical ventilation, or visits to urgent care or emergency room due to exacerbations of asthma AND
4. ONE of the following:
    i. There is evidence of a claim within the past 90 days that the patient is being treated with standard therapy (e.g. inhaled corticosteroids, long-acting beta-2 agonist (LABA), leukotriene receptor antagonist (LRTA), long-acting muscarinic antagonist (LAMA), theophylline) OR
    ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a standard therapy AND

5. Patient will NOT receive the requested agent in combination with Xolair or with another interleukin 5 (IL-5) inhibitor for the requested indication (e.g. Cinqair, Nucala) AND
6. The dose requested is within the FDA labeled dosing

Prior Authorization Group – **Fentanyl Nasal PA - Lazanda**

Drug Name(s):
LAZANDA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of chronic cancer pain due to an active malignancy AND there is evidence of a claim that the patient is currently taking a long-acting opioid with the nasal fentanyl within the past 90 days OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. Patient is NOT currently receiving any other oral or nasal fentanyl agent OR
    b. Patient is currently receiving another oral or nasal fentanyl agent AND will be discontinued prior to initiating the requested agent

Age Restrictions:
Patient is 18 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Fentanyl Oral PA - Abstral**

Drug Name(s):
ABSTRAL

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of chronic cancer pain due to an active malignancy AND there is evidence of a claim that the patient is currently taking a long-acting opioid with the oral fentanyl within the past 90 days OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. Patient is NOT currently receiving any other oral or nasal fentanyl agent OR
    b. Patient is currently receiving another oral or nasal fentanyl agent AND will be discontinued prior to initiating the requested agent

Age Restrictions:
Patient is 18 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Fentanyl Oral PA - Fentanyl lozenge**

Drug Name(s):
ACTIQ
fentanyl citrate oral lozenge

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of chronic cancer pain due to an active malignancy AND there is evidence of a claim that the patient is currently taking a long-acting opioid with the oral fentanyl within the past 90 days OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. Patient is NOT currently receiving any other oral or nasal fentanyl agent OR
    b. Patient is currently receiving another oral or nasal fentanyl agent AND will be discontinued prior to initiating the requested agent

Age Restrictions:
Patient is 16 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Fentanyl Oral PA - Fentora**

Drug Name(s):
FENTORA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of chronic cancer pain due to an active malignancy AND there is evidence of a claim that the patient is currently taking a long-acting opioid with the oral fentanyl within the past 90 days OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. Patient is NOT currently receiving any other oral or nasal fentanyl agent OR
    b. Patient is currently receiving another oral or nasal fentanyl agent AND will be discontinued prior to initiating the requested agent

Age Restrictions:
Patient is 18 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Fentanyl Oral PA - Subsys**

Drug Name(s):
SUBSYS

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of chronic cancer pain due to an active malignancy AND there is evidence of a claim that the patient is currently taking a long-acting opioid with the oral fentanyl within the past 90 days OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. Patient is NOT currently receiving any other oral or nasal fentanyl agent OR
    b. Patient is currently receiving another oral or nasal fentanyl agent AND will be discontinued prior to initiating the requested agent

Age Restrictions:
Patient is 18 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Firdapse PA**

Drug Name(s):
FIRDAPSE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require the following:
1. Patient has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) confirmed by at least ONE of the following:
A. Electrodiagnostic studies (e.g., electromyography) OR
B. Antibody testing

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) AND
3. Patient has shown clinical benefit with the requested agent

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g., neurologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Forteo PA**

Drug Name(s):
FORTEO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
An increased baseline risk for osteosarcoma

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    a. Postmenopausal female with osteoporosis OR
    b. Male with primary or hypogonadal osteoporosis OR
    c. Osteoporosis with sustained systemic glucocorticoid therapy AND
2. ONE of the following:
    a. Patient has a history of vertebral fracture(s), or low trauma or fragility fracture(s) [e.g. prior fracture from minor trauma such as falling from standing height or less] within the past 5 years OR
    b. Patient has a T-score that is -2.5 or lower (greater than or equal to 2.5 SD below the mean BMD value for a young adult) AND ONE of the following:
        i. Patient is female and has failed either a bisphosphonate or SERM OR
        ii. Patient is male and has failed a bisphosphonate OR
        iii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a SERM or bisphosphonate (bisphosphonate or SERM for female patients, bisphosphonates only for male patients) AND
3. ONE of the following:
    a. Patient is not receiving concomitant bisphosphonate, SERM, Prolia (denosumab), or Xgeva (denosumab) therapy within the past 90 days OR
    b. Prescriber indicates that the patient will discontinue the current bisphosphonate, SERM, Prolia (denosumab) or Xgeva (denosumab) therapy prior to initiating therapy with the requested agent AND
4. The dose requested is within the FDA approved labeling AND
5. The total duration of treatment with Forteo has not exceeded 2 years

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
No prior Forteo use approve 2 yrs, Prior Forteo use approve remainder of 2 yrs of total therapy

Other Criteria:

Prior Authorization Group – **Galafold PA**

Drug Name(s):
GALAFOLD

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Fabry disease AND
2. Diagnosis was confirmed by mutation of alpha-galactosidase A (alpha-gal A) gene AND
3. Patient has an amenable galactosidase alpha gene (GLA) variant mutation AND
4. Prescriber has evaluated at least ONE of the following: kidney function (proteinuria, GFR), cardiac function (left ventricular hypertrophy, conduction or rhythm, mitral or aortic insufficiency), optic neuropathy, neuropathic pain, and/or gastrointestinal symptoms AND
5. ONE of the following:
    A. Patient is NOT currently being treated with enzyme replacement therapy (ERT) indicated for Fabry disease (e.g. Fabrazyme) OR
    B. Patient is currently being treated with ERT indicated for Fabry disease AND will discontinue prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Prescriber has indicated that the patient has shown clinical benefit with the requested agent (e.g. improvements and/or stabilization of at least ONE of the following: kidney function (proteinuria, GFR), cardiac function (left ventricular hypertrophy, conduction or rhythm, mitral or aortic insufficiency), optic neuropathy, neuropathic pain, and/or gastrointestinal symptoms) AND
3. ONE of the following:
    A. Patient is NOT currently being treated with enzyme replacement therapy (ERT) indicated for Fabry disease (e.g. Fabrazyme) OR
    B. Patient is currently being treated with ERT indicated for Fabry disease AND will discontinue prior to continuing the requested agent

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. endocrinologist, geneticist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Gamastan PA**

Drug Name(s):
GAMASTAN S/D

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has ONE of the following diagnoses:
    A. Primary immunodeficiency (including congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency) OR
    B. Multiple sclerosis (MS) AND BOTH of the following:
        i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND
        ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication(s) to TWO MS agents (e.g. Aubagio, Avonex, Betaseron, glatiramer (i.e. Copaxone, Glatopa), Plegridy, Tecfidera or Tysabri) OR
    C. Hepatitis A infection prophylaxis AND exposure occurred within the past 2 weeks OR
    D. Measles (rubeola) prophylaxis AND BOTH of the following:
        i. Patient is considered susceptible to infection (a susceptible person is defined as one who has not been vaccinated and has not had measles previously) AND
        ii. Patient was exposed to measles (rubeola) within the past 6 days OR
    E. Passive immunization against varicella AND BOTH of the following:
        i. Patient is immunocompromised AND
        ii. Varicella-Zoster immune globulin is unavailable OR
    F. Rubella prophylaxis in exposed pregnant woman AND the patient is considered susceptible to infection (a susceptible person is defined as one who has not been vaccinated and has not had rubella previously) OR
2. ONE of the following:
    A. Patient has another FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
For prophylaxis diagnoses: see Other Criteria, for all other diagnoses 12 months

Other Criteria:
Prophylaxis indication with 3 month approval: Hepatitis A infection prophylaxis

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

Prior Authorization Group – **Gammagard/Gammaked/Gamunex-C PA**

Drug Name(s):
GAMMAGARD
GAMMAGARD SD
GAMMAKED
GAMUNEX-C

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has ONE of the following diagnoses:
    A. Primary immunodeficiency (including congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency) OR
    B. Chronic lymphocytic leukemia OR multiple myeloma with reduced IgG AND ONE of the following:
        i. Patient has a history of infections OR
        ii. Patient has evidence of specific antibody deficiency OR
    C. Idiopathic thrombocytopenia purpura AND ONE of the following:
        i. Patient has failed ONE conventional therapy (e.g. corticosteroids (e.g. methylprednisolone), or immunosuppressants (e.g. azathioprine)) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    D. Dermatomyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy (e.g. corticosteroids (e.g. methylprednisolone) or immunosuppressants (e.g. azathioprine)) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    E. Polymyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy (e.g. corticosteroids (e.g. methylprednisolone) or immunosuppressants (e.g. azathioprine)) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    F. Severe rheumatoid arthritis AND ONE of the following:

i. Patient has failed ONE conventional therapy (e.g. tumor necrosis factor antagonists (e.g. Humira), DMARDS (e.g. methotrexate), Renflexis) OR
ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

Criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 3 months for indications in NHS guidelines, 12 months all others

Other Criteria:
G. Myasthenia gravis (MG) AND ONE of the following:
i. Patient is in acute myasthenic crisis with decompensation (e.g. acute episode of respiratory muscle weakness, respiratory failure, dysphagia, major functional disability responsible for the discontinuation of physical activity) OR
ii. Patient has severe refractory MG (e.g. major functional disability/weakness) AND ONE of the following:
a) Patient has failed ONE immunomodulator therapy (i.e. corticosteroid, pyridostigmine, or azathioprine) OR
b) Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE immunomodulator therapy OR
H. Multiple sclerosis (MS) AND BOTH of the following:
i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND
ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication(s) to TWO MS agents (e.g. Aubagio, Avonex, Betaseron, glatiramer (i.e. Copaxone, Glatopa), Plegridy, Tecfidera or Tysabri) OR
I. Acquired von Willebrand hemophilia AND ONE of the following:
i. Patient has failed ONE conventional therapy (e.g. desmopressin solution, von Willebrand factor replacement therapy, corticosteroids, cyclophosphamide, FEIBA, Rituxan, or recombinant factor VIIa) OR
ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
J. Refractory pemphigus vulgaris AND ONE of the following:
i. Patient has failed ONE conventional immunosuppressive therapy (e.g. azathioprine, cyclophosphamide, mycophenolate, corticosteroids) OR
ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional immunosuppressive therapy OR
2. ONE of the following:

A. Patient has another FDA labeled indication for the requested agent OR
B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Indications with 3 month approval duration:
Idiopathic thrombocytopenia purpura, Acquired von Willebrand hemophilia, Guillain-Barre Syndrome, Lambert-Eaton myasthenia syndrome, Myasthenia gravis, Kawasaki disease, CMV induced pneumonitis in solid organ transplant, Toxic shock syndrome due to invasive group A streptococcal, Toxic epidermal necrolysis and Steven Johnsons syndrome

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

Prior Authorization Group – **Gattex PA**

Drug Name(s):
GATTEX

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of short bowel syndrome (SBS) AND
2. Patient is dependent on parenteral nutrition OR intravenous (PN/IV) fluids AND
3. Patient has had a colonoscopy with any polyps removed, if present, within the last 6 months

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of short bowel syndrome (SBS) AND
3. Patient has had a reduction from baseline in parenteral nutrition OR intravenous (PN/IV) fluids

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Initial approval 6 months. Renewal approval 12 months.

Other Criteria:

Prior Authorization Group – **Gaucher Enzyme Replacement PA - Cerezyme**

Drug Name(s):
CEREZYME

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Gaucher disease type 1 confirmed by ONE of the following:
    A. A baseline glucocerebrosidase enzyme activity of less than 15% of mean normal in peripheral blood leukocytes, fibroblasts, or other nucleated cells OR
    B. Confirmation of genetic mutation of GBA gene with two disease-causing alleles AND
2. Prescriber has drawn baseline levels of hemoglobin, platelets, liver volume, and spleen volume AND
3. Prior to any treatment for the intended diagnosis, the patient has had ONE of the following:
    A. Anemia (defined as mean hemoglobin (Hb) level below the testing laboratory's lower limit of the normal range based on age and gender) OR
    B. Thrombocytopenia (defined as a platelet count of less than 100,000 per microliter) OR
    C. Hepatomegaly OR
    D. Splenomegaly OR
    E. Growth failure (growth velocity below the standard mean for age) OR
    F. Evidence of bone disease with other causes ruled out

Criteria for renewal require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of Gaucher's disease type 1 AND
3. Patient has shown clinical improvement and/or stabilization from baseline in ONE of the following:
    A. Hemoglobin (Hb) levels OR
    B. Platelet count OR
    C. Hepatomegaly OR
    D. Splenomegaly OR
    E. Growth OR

F. Bone pain or disease

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. endocrinologist, geneticist, hematologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Gaucher Enzyme Replacement PA - Elelyso**

Drug Name(s):
ELELYSO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Gaucher disease type 1 confirmed by ONE of the following:
    A. A baseline glucocerebrosidase enzyme activity of less than 15% of mean normal in peripheral blood leukocytes, fibroblasts, or other nucleated cells OR
    B. Confirmation of genetic mutation of GBA gene with two disease-causing alleles AND
2. Prescriber has drawn baseline levels of hemoglobin, platelets, liver volume, and spleen volume AND
3. Prior to any treatment for the intended diagnosis, the patient has had ONE of the following:
    A. Anemia (defined as mean hemoglobin (Hb) level below the testing laboratory's lower limit of the normal range based on age and gender) OR
    B. Thrombocytopenia (defined as a platelet count of less than 100,000 per microliter) OR
    C. Hepatomegaly OR
    D. Splenomegaly OR
    E. Growth failure (growth velocity below the standard mean for age) OR
    F. Evidence of bone disease with other causes ruled out

Criteria for renewal require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of Gaucher's disease type 1 AND
3. Patient has shown clinical improvement and/or stabilization from baseline in ONE of the following:
    A. Hemoglobin (Hb) levels OR
    B. Platelet count OR
    C. Hepatomegaly OR
    D. Splenomegaly OR
    E. Growth OR

F. Bone pain or disease

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. endocrinologist, geneticist, hematologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Gaucher Enzyme Replacement PA - Vpriv**

Drug Name(s):
VPRIV

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Gaucher disease type 1 confirmed by ONE of the following:
    A. A baseline glucocerebrosidase enzyme activity of less than 15% of mean normal in peripheral blood leukocytes, fibroblasts, or other nucleated cells OR
    B. Confirmation of genetic mutation of GBA gene with two disease-causing alleles AND
2. Prescriber has drawn baseline levels of hemoglobin, platelets, liver volume, and spleen volume AND
3. Prior to any treatment for the intended diagnosis, the patient has had ONE of the following:
    A. Anemia (defined as mean hemoglobin (Hb) level below the testing laboratory's lower limit of the normal range based on age and gender) OR
    B. Thrombocytopenia (defined as a platelet count of less than 100,000 per microliter) OR
    C. Hepatomegaly OR
    D. Splenomegaly OR
    E. Growth failure (growth velocity below the standard mean for age) OR
    F. Evidence of bone disease with other causes ruled out

Criteria for renewal require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of Gaucher's disease type 1 AND
3. Patient has shown clinical improvement and/or stabilization from baseline in ONE of the following:
    A. Hemoglobin (Hb) levels OR
    B. Platelet count OR
    C. Hepatomegaly OR
    D. Splenomegaly OR
    E. Growth OR

F. Bone pain or disease

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. endocrinologist, geneticist, hematologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Growth Hormone PA - Genotropin**

Drug Name(s):
GENOTROPIN
GENOTROPIN MINIQUICK

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
For Children – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient is a neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder AND
        i. The GH level is less than 20 ng/mL OR
    b. Patient has a diagnosis of Turner Syndrome OR
    c. Patient has a diagnosis of Prader-Willi Syndrome OR
    d. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR
    e. Patient has a diagnosis of growth hormone deficiency (GHD) or short stature AND BOTH of the following:
        i. ONE of the following:
            a) Height more than 2 standard deviations (SD) below the mean for age and sex OR
            b) Height more than 1.5 SD below the midparental height OR
                c) A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over two years AND
        ii. Failure of at least 2 GH stimulation tests (peak GH value of less than 10 mcg/L after stimulation) OR
    f. Patient has a diagnosis of small for gestational age (SGA) AND ALL of the following:
        i. Patient is at least 2 years of age AND
        ii. Documented birth weight and/or length that is 2 or more standard deviations (SD) below the mean for gestational age AND

iii. At 24 months of age, the patient fails to manifest catch-up growth evidenced by a height 2 or more SD below the mean for age and sex AND

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
For Children – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has been diagnosed with ONE of the following:
   a. Neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder OR
   b. Growth Hormone Deficiency, Short Stature OR
   c. Panhypopituitarism OR
   d. Prader-Willi Syndrome OR
   e. Small for Gestational Age OR
   f. Turner Syndrome AND
3. ALL of the following:
   a. Patient does not have closed epiphyses AND
   b. Patient is being monitored for adverse effects of therapy with the requested agent AND
   c. Patient's height is increased or height velocity has improved since initiation or last approval of the requested agent

For Adults – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
   a. Patient has a diagnosis of childhood growth hormone deficiency (GHD) with genetic or organic origin AND ONE of the following:
      i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR
      ii. Failure of at least one growth hormone (GH) stimulation test as an adult (peak GH value of 5 mcg/L or lower after stimulation) OR
   b. Patient has a diagnosis of acquired adult GHD secondary to structural lesions or trauma AND ONE of the following:
      i. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:

a) Deficiencies in 3 or more pituitary axes AND
b) Low IGF-1 level without GH replacement therapy OR

ii. Patient has failed at least one GH stimulation test as an adult OR

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

2. ONE of the following:

a. Patient has tried and failed the preferred agent [Omnitrope] OR

b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

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

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

2. Patient has been diagnosed with ONE of the following:

a. Childhood growth hormone deficiency (GHD) with genetic or organic origin OR

b. Acquired adult GHD secondary to structural lesions or trauma OR

c. Other (e.g., childhood idiopathic GHD, adult-onset idiopathic GHD) AND

3. Patient is being monitored for adverse effects of therapy with the requested agent AND

4. Patient's IGF-1 level has been evaluated to confirm the appropriateness of the current dose AND

5. Patient has had benefits from therapy with the requested agent in any of the following response parameters: body composition, hip-to-waist ratio, cardiovascular health, bone mineral density, serum cholesterol, physical strength, or quality of life

Prior Authorization Group – **Growth Hormone PA - Humatrope**

Drug Name(s):
HUMATROPE
HUMATROPE COMBO PACK

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
For Children – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient is a neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder* AND
        i. The GH level is less than 20 ng/mL OR
    b. Patient has a diagnosis of Turner Syndrome* OR
    c. Patient has a diagnosis of SHOX gene deficiency OR
    d. Patient has a diagnosis of panhypopituitarism* AND BOTH of the following:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR
    e. Patient has a diagnosis of growth hormone deficiency (GHD)* or short stature* AND BOTH of the following:
        i. ONE of the following:
            a) Height more than 2 standard deviation (SD) below the mean for age and sex OR
            b) Height more than 1.5 SD below the midparental height OR
            c) A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over 2 years AND
        ii. Failure of at least 2 GH stimulation tests (peak GH value of less than 10 mcg/L after stimulation) OR
    f. Patient has a diagnosis of small for gestational age* AND ALL of the following:
        i. Patient is at least 2 years of age AND
        ii. Documented birth weight and/or length that is 2 or more SD below the mean for gestational age AND

iii. At 24 months of age, the patient fails to manifest catch-up growth evidenced by a height 2 or more SD below the mean for age and sex AND

2. Patient's diagnosis is indicated in the preferred GH agent AND ONE of the following:
   a. Patient has tried and failed the preferred agent [Omnitrope] OR
   b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
For Children – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has been diagnosed with ONE of the following:
   a. Neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder OR
   b. Growth Hormone Deficiency, Short Stature OR
   c. Panhypopituitarism OR
   d. Small for Gestational Age OR
   e. SHOX gene deficiency OR
   f. Turner Syndrome AND
3. ALL of the following:
   a. Patient does not have closed epiphyses AND
   b. Patient is being monitored for adverse effects of therapy with the requested agent AND
   c. Patient's height is increased or height velocity has improved since initiation or last approval of the requested agent

For Adults – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
   a. Patient has a diagnosis of childhood growth hormone deficiency (GHD) with genetic or organic origin AND ONE of the following:
      i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR
      ii. Failure of at least one growth hormone (GH) stimulation test as an adult (peak GH value of 5 mcg/L or lower after stimulation) OR

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

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

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

Prior Authorization Group – **Growth Hormone PA - Norditropin**

Drug Name(s):
NORDITROPIN FLEXPRO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
For Children – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient is a neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder* AND
        i. The GH level is less than 20 ng/mL OR
    b. Patient has a diagnosis (dx) of Turner Syndrome* OR
    c. Patient has a dx of Prader-Willi Syndrome* OR
    d. Patient has a dx of Noonan Syndrome OR
    e. Patient has a dx of panhypopituitarism* AND BOTH of the following:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR
    f. Patient has a dx of growth hormone deficiency (GHD)* or short stature* AND BOTH of the following:
        i. ONE of the following:
            a) Height (Ht) more than 2 standard deviations (SD) below the mean for age and sex OR
            b) Ht more than 1.5 SD below the midparental ht OR
            c) A decrease in ht SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Ht velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over 2 years AND
        ii. Failure of at least 2 GH stimulation tests (peak GH value of less than 10 mcg/L after stimulation) OR
    g. Patient has a dx of small for gestational age* AND ALL of the following:
        i. Patient is at least 2 years of age AND
        ii. Documented birth weight and/or length that is 2 or more SD below the mean for gestational age AND

iii. At 24 months of age, the patient fails to manifest catch-up growth evidenced by a ht 2 or more SD below the mean for age and sex AND

2. Patient's dx is indicated in the preferred GH agent AND ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

NOTE:
*Use of the preferred agent [Omnitrope] is required
NO prerequisites are required for the dx of Noonan Syndrome

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
For Children – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder OR
    b. Growth Hormone Deficiency (GHD), Short Stature OR
    c. Noonan Syndrome OR
    d. Panhypopituitarism OR
    e. Small for Gestational Age OR
    f. Turner Syndrome OR
    g. Prader-Willi Syndrome AND
3. ALL of the following:
    a. Patient does not have closed epiphyses AND
    b. Patient is being monitored for adverse effects of therapy with the requested agent AND
    c. Patient's height is increased or height velocity has improved since initiation or last approval of the requested agent

For Adults – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of childhood GHD with genetic or organic origin AND ONE of the following:
        i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR

ii. Failure of at least one growth hormone (GH) stimulation test as an adult (peak GH value of 5 mcg/L or lower after stimulation) OR

b. Patient has a diagnosis of acquired adult GHD secondary to structural lesions or trauma AND ONE of the following:

i. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:

a) Deficiencies in 3 or more pituitary axes AND

b) Low IGF-1 level without GH replacement therapy OR

ii. Patient has failed at least one growth hormone (GH) stimulation test as an adult OR

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

2. ONE of the following:

a. Patient has tried and failed the preferred agent [Omnitrope] OR

b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

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

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

2. Patient has been diagnosed with ONE of the following:

a. Childhood growth hormone deficiency (GHD) with genetic or organic origin OR

b. Acquired adult GHD secondary to structural lesions or trauma OR

c. Other (e.g. childhood idiopathic GHD, adult-onset idiopathic GHD) AND

3. Patient is being monitored for adverse effects of therapy with the requested agent AND

4. Patient's IGF-1 level has been evaluated to confirm the appropriateness of the current dose AND

5. Patient has had benefits from therapy with the requested agent in any of the following response parameters: body composition, hip-to-waist ratio, cardiovascular health, bone mineral density, serum cholesterol, physical strength, or quality of life

Prior Authorization Group – **Growth Hormone PA - Nutropin**

Drug Name(s):
NUTROPIN AQ NUSPIN

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
For Children – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient (Pt) is a neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder* AND
        i. The GH level is less than 20 ng/mL OR
    b. Pt has a diagnosis (dx) of Turner Syndrome* OR
    c. Pt has a dx of chronic renal insufficiency AND BOTH of the following:
        i. Height (Ht) is more than 2 standard deviations (SD) below the mean (less than the third percentile) compared to normal children of the same age and sex AND
        ii. Other etiologies for growth retardation have been ruled out OR
    d. Pt has a dx of panhypopituitarism* AND BOTH of the following:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum insulin-like growth factor-1 levels are below the age and sex-appropriate reference range when off GH therapy OR
    e. Pt has a dx of growth hormone deficiency (GHD)* or short stature* AND BOTH of the following:
        i. ONE of the following:
            a) Ht more than 2 SD below the mean for age and sex OR
            b) Ht more than 1.5 SD below the midparental height OR
            c) A decrease in ht SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Ht velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over 2 years AND
        ii. Failure of at least 2 GH stimulation tests (peak GH value of less than 10 mcg/L after stimulation) AND
2. Patient's dx is indicated in the preferred GH agent AND ONE of the following:
    a. Pt has tried and failed the preferred agent [Omnitrope] OR

b. Pt has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

NOTE:
*Use of the preferred agent [Omnitrope] is required
NO prerequisites are required for the dx of chronic renal insufficiency

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
For Children – Criteria for renewal approval require ALL of the following:
1. Pt has been previously approved for the requested agent through the plan's PA criteria AND
2. Pt has been diagnosed with ONE of the following:
    a. Neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder OR
    b. Growth Hormone Deficiency, Short Stature OR
    c. Chronic renal insufficiency OR
    d. Panhypopituitarism OR
    e. Turner Syndrome AND
3. ALL of the following:
    a. Pt does not have closed epiphyses AND
    b. Pt is being monitored for adverse effects of therapy with the requested agent AND
    c. Pt's ht is increased or ht velocity has improved since initiation or last approval of the requested agent

For Adults – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Pt has a dx of childhood growth hormone deficiency (GHD) with genetic or organic origin AND ONE of the following:
        i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR
        ii. Failure of at least one growth hormone (GH) stimulation test as an adult (peak GH value of 5 mcg/L or lower after stimulation) OR
    b. Pt has a dx of acquired adult GHD secondary to structural lesions or trauma AND ONE of the following:
        i. Pt has a dx of panhypopituitarism AND BOTH of the following:
            a) Deficiencies in 3 or more pituitary axes AND
            b) Low IGF-1 level without GH replacement therapy OR

ii. Pt has failed at least one growth hormone (GH) stimulation test as an adult OR

c. Pt has a dx of idiopathic GHD (adult or childhood onset) AND the pt has failed at least two growth hormone (GH) stimulation tests as an adult AND

2. ONE of the following:

a. Pt has tried and failed the preferred agent [Omnitrope] OR

b. Pt has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

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

1. Pt has been previously approved for the requested agent through the plan's PA criteria AND

2. Pt has been diagnosed with ONE of the following:

a. Childhood growth hormone deficiency (GHD) with genetic or organic origin OR

b. Acquired adult GHD secondary to structural lesions or trauma OR

c. Other (e.g. childhood idiopathic GHD, adult-onset idiopathic GHD) AND

3. Pt is being monitored for adverse effects of therapy with the requested agent AND

4. Pt's IGF-1 level has been evaluated to confirm the appropriateness of the current dose AND

5. Pt has had benefits from therapy with the requested agent in any of the following response parameters: body composition, hip-to-waist ratio, cardiovascular health, bone mineral density, serum cholesterol, physical strength, or quality of life

Prior Authorization Group – **Growth Hormone PA - Omnitrope**

Drug Name(s):
OMNITROPE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
For Children – Criteria for initial approval require the following:
1. ONE of the following:
    a. Patient is a neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder AND
        i. The GH level is less than 20 ng/mL OR
    b. Patient has a diagnosis of Turner Syndrome OR
    c. Patient has a diagnosis of Prader-Willi Syndrome OR
    d. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR
    e. Patient has a diagnosis of growth hormone deficiency (GHD) or short stature AND BOTH of the following:
        i. Patient has ONE of the following:
            a) Height more than 2 standard deviations (SD) below the mean for age and sex OR
            b) Height more than 1.5 SD below the midparental height OR
            c) A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over two years AND
        ii. Failure of at least 2 growth hormone (GH) stimulation tests (peak GH value of less than 10 mcg/L after stimulation) OR
    f. Patient has a diagnosis of small for gestational age (SGA) AND ALL of the following:
        i. Patient is at least 2 years of age AND
        ii. Documented birth weight and/or length that is 2 or more standard deviations (SD) below the mean for gestational age AND

iii. At 24 months of age, the patient fails to manifest catch-up growth evidenced by a height 2 or more SD below the mean for age and sex

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
For Children – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the preferred agent through the plan's PA criteria AND
2. Patient has been diagnosed with ONE of the following:
    a. Neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder OR
    b. Growth Hormone Deficiency, Short Stature OR
    c. Panhypopituitarism OR
    d. Prader-Willi Syndrome OR
    e. Small for Gestational Age (SGA) OR
    f. Turner Syndrome AND
3. ALL of the following:
    a. Patient does not have closed epiphyses AND
    b. Patient is being monitored for adverse effects of therapy with the requested agent AND
    c. Patient's height is increased or height velocity has improved since initiation or last approval of the requested agent

For Adults – Criteria for initial approval require the following:
1. Patient has been diagnosed with ONE of the following:
    a. Childhood growth hormone deficiency (GHD) with genetic or organic origin AND ONE of the following:
        i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR
        ii. Failure of at least one growth hormone (GH) stimulation test as an adult (peak GH value of 5 mcg/L or lower after stimulation) OR
    b. Acquired adult GHD secondary to structural lesions or trauma AND ONE of the following:
        i. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:

a) Deficiencies in 3 or more pituitary axes AND
b) Low IGF-1 level without GH replacement therapy OR

ii. Patient has failed at least one growth hormone (GH) stimulation test as an adult OR

c. Idiopathic GHD (adult or childhood onset) AND the patient has failed at least two growth hormone (GH) stimulation tests as an adult

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

Prior Authorization Group – **Growth Hormone PA - Saizen**

Drug Name(s):

SAIZEN
SAIZEN CLICK.EASY
SAIZENPREP RECONSTITUTION KIT

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

FDA labeled contraindication(s) to the requested agent

Required Medical:

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

1. ONE of the following:
    a. Patient is a neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder AND
        i. The GH level is less than 20 ng/mL OR
    b. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR
    c. Patient has a diagnosis of growth hormone deficiency (GHD) or short stature AND BOTH of the following:
        i. ONE of the following:
            a) Height more than 2 standard deviations (SD) below the mean for age and sex OR
            b) Height more than 1.5 SD below the midparental height OR
            c) A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over two years AND
        ii. Failure of at least 2 GH stimulation tests (peak GH value of less than 10 mcg/L after stimulation) AND
2. ONE of the following:
    a. Patient has tried and failed the preferred agent [Omnitrope] OR
    b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agent [Omnitrope]

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
For Children – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria
AND
2. Patient has been diagnosed with ONE of the following:
    a. Neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder OR
    b. Growth Hormone Deficiency, Short Stature OR
    c. Panhypopituitarism AND
3. ALL of the following:
    a. Patient does not have closed epiphyses AND
    b. Patient is being monitored for adverse effects of therapy with the requested agent AND
    c. Patient's height is increased or height velocity has improved since initiation or last approval of the requested agent

For Adults – Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    a. Patient has a diagnosis of childhood growth hormone deficiency (GHD) with genetic or organic origin AND ONE of the following:
        i. Low IGF-1 (insulin-like growth factor-1) level without GH replacement therapy OR
        ii. Failure of at least one growth hormone (GH) stimulation test as an adult (peak GH value of 5 mcg/L or lower after stimulation) OR
    b. Patient has a diagnosis of acquired adult GHD secondary to structural lesions or trauma AND ONE of the following:
        i. Patient has a diagnosis of panhypopituitarism AND BOTH of the following:
            a) Deficiencies in 3 or more pituitary axes AND
            b) Low IGF-1 level without GH replacement therapy OR
        ii. Patient has failed at least one growth hormone (GH) stimulation test as an adult OR

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

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

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

Prior Authorization Group – **Growth Hormone PA - Serostim**

Drug Name(s):
SEROSTIM

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require BOTH of the following:
1. The requested agent is for the treatment of an HIV patient with wasting or cachexia AND
2. BOTH of the following:
    a. Patient is currently receiving antiretroviral therapy AND
    b. ONE of the following:
        i. Patient has had an unintentional weight loss of 10% or more of body weight over 12 months OR
        ii. Patient has had an unintentional weight loss of greater than 7.5% over 6 months OR
        iii. Patient has a mid-upper arm circumference less than 10th percentile OR
        iv. Patient has a body cell mass (BCM) loss of 5% or more over 6 months OR
        v. Patient has a BCM less than 35% for males or less than 23% for females AND a BMI of less than 27 kg/m2

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria
AND
2. The requested agent is for the treatment of an HIV patient with wasting or cachexia AND
3. BOTH of the following:
    a. Patient is receiving antiretroviral therapy and growth hormone therapy concurrently AND
    b. Patient has had clinical improvement with the requested agent (e.g., weight increase or weight stabilization)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 weeks

Other Criteria:

Prior Authorization Group – **Growth Hormone PA - Zomacton**

Drug Name(s):
ZOMACTON

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
For Children – Criteria for initial approval require BOTH of:
1. ONE of:
    a. Patient (pt) is a neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder* AND
        i. The GH level is less than 20 ng/mL OR
    b. Pt has a diagnosis (dx) of Turner Syndrome* OR
    c. Pt has a dx of SHOX gene deficiency OR
    d. Pt has a dx of panhypopituitarism* AND BOTH of:
        i. Deficiencies in 3 or more pituitary axes AND
        ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR
    e. Pt has a dx of growth hormone deficiency (GHD)* or short stature* AND BOTH of:
        i. ONE of:
            a) Height more than 2 standard deviations (SD) below the mean for age and sex OR
            b) Height more than 1.5 SD below the midparental height OR
            c) A decrease in height SD of more than 0.5 over one year in children at least 2 years of age OR
            d) Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over two years AND
        ii. Failure of at least 2 GH stimulation tests (peak GH value of less than 10 mcg/L after stimulation) OR
    f. Pt has a dx of small for gestational age* AND ALL of:
        i. Pt is at least 2 years of age AND
        ii. Documented birth weight and/or length that is 2 or more SD below the mean for gestational age AND
        iii. At 24 months of age, pt fails to manifest catch-up growth evidenced by a height 2 or more SD below the mean for age and sex AND

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

NOTE:
*Use of the preferred agent [Omnitrope] is required for ALL of the following dxs:
a. Neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder
b. GHD, Short Stature
c. Panhypopituitarism
d. Small for Gestational Age
e. Turner Syndrome
NO prerequisites are required for the dx of SHOX gene deficiency

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
For Children – Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria
AND
2. Patient has been diagnosed with ONE of the following:
    a. Neonate (4 months of age or younger) with hypoglycemia in the absence of metabolic disorder OR
    b. Growth Hormone Deficiency, Short Stature OR
    c. Panhypopituitarism OR
    d. Small for Gestational Age OR
    e. SHOX gene deficiency OR
    f. Turner Syndrome AND
3. ALL of the following:
    a. Patient does not have closed epiphyses AND
    b. Patient is being monitored for adverse effects of therapy with the requested agent AND
    c. Patient's height is increased or height velocity has improved since initiation or last approval of the requested agent

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

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

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

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

Prior Authorization Group – **Growth Hormone PA - Zorbtive**

Drug Name(s):
ZORBTIVE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of short bowel syndrome AND
2. Patient is receiving enteral or parenteral nutritional support, or other specialized nutritional support

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of short bowel syndrome AND
3. Patient has had clinical improvement with the requested agent (e.g., decrease in enteral or parenteral nutrition requirements)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 4 weeks

Other Criteria:

Prior Authorization Group – **HAE PA - Berinert**

Drug Name(s):
BERINERT

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been diagnosed with measurement of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Type I HAE: Two separate measurements indicating decreased quantities of C4 and C1-INH OR
    b. Type II HAE: Two separate measurements indicating decreased quantities of C4 and decreased C1-INH function (C1-INH protein level may be normal) OR
    c. Type III HAE: Normal levels of C4 and C1-INH (at baseline and during an attack) AND ONE of the following:
        i. Family history of angioedema OR
        ii. Patient demonstrates a Factor XII mutation that is associated with the disease AND
2. Medications known to cause angioedema (i.e. ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. The requested agent will be used to treat acute HAE attacks AND
4. ONE of the following:
    a. Patient is receiving only ONE agent indicated for treatment of acute HAE attacks OR
    b. The other agent being used for acute HAE attacks will be discontinued before starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of hereditary angioedema (HAE) AND
3. The requested agent will be used to treat acute HAE attacks AND
4. ONE of the following:
    a. Patient is receiving only ONE agent indicated for treatment of acute HAE OR
    b. The other agent being used for acute HAE attacks will be discontinued before starting the requested agent AND
5. Patient has had a decrease in the frequency of acute attacks or stabilization of disease from use of the requested agent

Prior Authorization Group – **HAE PA - Cinryze**

Drug Name(s):
CINRYZE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D, plus the off-label use for acute HAE attacks.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been diagnosed with measurement of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Type I HAE: Two separate measurements indicating decreased quantities of C4 and C1-INH OR
    b. Type II HAE: Two separate measurements indicating decreased quantities of C4 and decreased C1-INH function (C1-INH protein level may be normal) OR
    c. Type III HAE: Normal levels of C4 and C1-INH (at baseline and during an attack) AND ONE of the following:
        i. Family history of angioedema OR
        ii. Patient demonstrates a Factor XII mutation that is associated with the disease AND
2. Medications known to cause angioedema (i.e. ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. ONE of the following:
    a. The requested agent will be used to treat acute HAE attacks AND ONE of the following:
        i. Patient is receiving only ONE agent indicated for treatment of acute HAE OR
        ii. The other agent being used for acute HAE attacks will be discontinued before starting the requested agent OR
    b. The requested agent will be used for prophylaxis against HAE attacks AND ALL of the following:
        i. ONE of the following:
            1. Patient is receiving only ONE HAE agent indicated for prophylaxis against HAE attacks OR
            2. The other agent being used for prophylaxis will be discontinued before starting the requested agent AND

ii. Patient has a history of at least 2 acute attacks per month OR 2 severe attacks (laryngeal or abdominal attacks) per year OR for short-term prophylaxis if prior to medical, surgical, or dental procedure AND
iii. ONE of the following:
1. Patient has tried a formulary 17 alpha-alkylated androgen or antifibrinolytic agent OR
2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a formulary 17 alpha-alkylated androgen or antifibrinolytic agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of hereditary angioedema (HAE) AND ONE of the following:
a. The requested indication is for acute HAE AND ONE of the following:
i. Patient is receiving only ONE agent indicated for treatment of acute HAE OR
ii. The other agent being used for acute HAE attacks will be discontinued before starting the requested agent OR
b. The requested indication is for prophylaxis of HAE attacks AND ONE of the following:
i. Patient is receiving only ONE HAE agent indicated for prophylaxis against HAE attacks OR
ii. The other agent being used for prophylaxis will be discontinued before starting the requested agent AND
3. Patient has had a decrease in the frequency of acute attacks or has had stabilization of disease from use of the requested agent

Prior Authorization Group – **HAE PA - Firazyr**

Drug Name(s):
FIRAZYR
icatibant 30 mg/3 mL injection

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been diagnosed with measurement of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Type I HAE: Two separate measurements indicating decreased quantities of C4 and C1-INH OR
    b. Type II HAE: Two separate measurements indicating decreased quantities of C4 and decreased C1-INH function (C1-INH protein level may be normal) OR
    c. Type III HAE: Normal levels of C4 and C1-INH (at baseline and during an attack) AND ONE of the following:
        i. Family history of angioedema OR
        ii. Patient demonstrates a Factor XII mutation that is associated with the disease AND
2. Medications known to cause angioedema (i.e. ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. The requested agent will be used to treat acute HAE attacks AND
4. ONE of the following:
    a. Patient is receiving only ONE agent indicated for treatment of acute HAE attacks OR
    b. The other agent being used for acute HAE attacks will be discontinued before starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of hereditary angioedema (HAE) AND
3. The requested agent will be used to treat acute HAE attacks AND
4. ONE of the following:
    a. Patient is receiving only ONE agent indicated for treatment of acute HAE OR
    b. The other agent being used for acute HAE attacks will be discontinued before starting the requested agent AND
5. Patient has had a decrease in the frequency of acute attacks or stabilization of disease from use of the requested agent

Prior Authorization Group – **HAE PA - Haegarda**

Drug Name(s):
HAEGARDA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been diagnosed with measurement of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Type I HAE: Two separate measurements indicating decreased quantities of C4 and C1-INH OR
    b. Type II HAE: Two separate measurements indicating decreased quantities of C4 and decreased C1-INH function (C1-INH protein level may be normal) OR
    c. Type III HAE: Normal levels of C4 and C1-INH (at baseline and during an attack) AND ONE of the following:
        i. Family history of angioedema OR
        ii. Patient demonstrates a Factor XII mutation that is associated with the disease AND
2. Medications known to cause angioedema (i.e. ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. The requested agent will be used for prophylaxis against HAE attacks AND BOTH of the following:
    a. Patient has a history of at least 2 acute attacks per month OR 2 severe attacks (laryngeal or abdominal attacks) per year OR for short-term prophylaxis prior to medical, surgical, or dental procedure AND
    b. ONE of the following:
        i. Patient has tried a formulary 17 alpha-alkylated androgen or antifibrinolytic agent OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a formulary 17 alpha-alkylated androgen or antifibrinolytic agent AND
4. ONE of the following:
    a. Patient is receiving only ONE HAE agent indicated for prophylaxis against HAE attacks OR

b. The other agent being used for prophylaxis will be discontinued before starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of hereditary angioedema (HAE) AND
3. The requested agent is being used for prophylaxis against HAE attacks AND
4. Patient has had a decrease in the frequency of acute attacks or has had stabilization of disease from use of the requested agent AND
5. ONE of the following:
    a. Patient is receiving only ONE HAE agent indicated for prophylaxis against HAE attacks OR
    b. The other agent being used for prophylaxis will be discontinued before starting the requested agent

Prior Authorization Group – **HAE PA - Ruconest**

Drug Name(s):
RUCONEST

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been diagnosed with measurement of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Type I HAE: Two separate measurements indicating decreased quantities of C4 and C1-INH OR
    b. Type II HAE: Two separate measurements indicating decreased quantities of C4 and decreased C1-INH function (C1-INH protein level may be normal) OR
    c. Type III HAE: Normal levels of C4 and C1-INH (at baseline and during an attack) AND ONE of the following:
        i. Family history of angioedema OR
        ii. Patient demonstrates a Factor XII mutation that is associated with the disease AND
2. Medications known to cause angioedema (i.e. ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. The requested agent will be used to treat acute HAE attacks AND
4. ONE of the following:
    a. Patient is receiving only ONE agent indicated for treatment of acute HAE attacks OR
    b. The other agent being used for acute HAE attacks will be discontinued before starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of hereditary angioedema (HAE) AND
3. The requested agent will be used to treat acute HAE attacks AND
4. ONE of the following:
    a. Patient is receiving only ONE agent indicated for treatment of acute HAE OR
    b. The other agent being used for acute HAE attacks will be discontinued before starting the requested agent AND
5. Patient has had a decrease in the frequency of acute attacks or stabilization of disease from use of the requested agent

Prior Authorization Group – **HAE PA - Takhzyro**

Drug Name(s):
TAKHZYRO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed with measurements of C1-INH antigenic level, C1-INH functional level, and C4 level as follows:
    a. Type I HAE: Two separate measurements indicating decreased quantities of C4 and C1-INH OR
    b. Type II HAE: Two separate measurements indicating decreased quantities of C4 and decreased C1-INH function (C1-INH protein level may be normal) OR
    c. Type III HAE: Normal levels of C4 and C1-INH (at baseline and during an attack) AND ONE of the following:
        i. BOTH of the following:
            1. Family history of angioedema AND
            2. ALL other causes of angioedema have been ruled out OR
        ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, or plasminogen (PLG) mutation that is associated with the disease AND
2. Medications known to cause angioedema (e.g. ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND
3. The requested agent will be used for prophylaxis against HAE attacks AND ONE of the following:
    a. Patient has a history of at least 2 acute attacks per month OR 2 severe attacks (laryngeal or abdominal attacks) per year OR
    b. Patient requires short-term prophylaxis prior to a medical, surgical, or dental procedure AND
4. ONE of the following:
    a. Patient is receiving only ONE HAE agent indicated for prophylaxis against HAE attacks OR
    b. The other agent being used for prophylaxis will be discontinued before starting the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of hereditary angioedema (HAE)
AND
3. The requested agent is being used for prophylaxis against HAE attacks AND
4. Patient has had a decrease in the frequency or severity of acute attacks or has had stabilization of disease from use of the requested agent AND
5. ONE of the following:
    a. Patient is receiving only ONE HAE agent indicated for prophylaxis against HAE attacks OR
    b. The other agent being used for prophylaxis will be discontinued before starting the requested agent

Prior Authorization Group – **Harvoni PA**

Drug Name(s):
HARVONI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The dosing of the requested agent is within the FDA labeled dosing or is AASLD/IDSA guideline supported

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist

Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported

Other Criteria:

Prior Authorization Group – **Hetlioz PA**

Drug Name(s):
HETLIOZ

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require the following:
1. Patient has a diagnosis of Non-24-Hour Sleep-Wake Disorder AND the patient is totally blind (i.e. no light perception)

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. neurologist, sleep specialist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **High Risk Medication PA - All Starts**

Drug Name(s):

BENTYL
benztropine tablet
butalbital/acetaminophen/caffeine/codeine 50-300-40-30 mg capsule
butalbital/acetaminophen/caffeine/codeine 50-325-40-30 mg capsule
butalbital/aspirin/caffeine/codeine 50-325-40-30 mg capsule
carbinoxamine solution, tablet
CLEMASTINE tablet
COGENTIN
cyproheptadine syrup, tablet
DEMEROL 100 mg tablet
dicyclomine capsule, injection, solution, tablet
diphenoxylate/atropine 2.5-0.025 mg tablet
DIPHENOXYLATE/ATROPINE 2.5-0.025 mg/5 mL liquid
disopyramide capsule
FIORICET/CODEINE
FIORINAL/CODEINE #3
HYDROXYZINE HCL injection
hydroxyzine hcl syrup, tablet
HYDROXYZINE PAMOATE 100 mg capsule
hydroxyzine pamoate 25 mg, 50 mg capsule
INTUNIV
LOMOTIL
MEPERIDINE 50 mg/5 mL solution
meperidine tablet
NORPACE
NORPACE CR
pentazocine/naloxone tablet
PHENERGAN
promethazine injection, suppository, syrup, tablet
PROMETHAZINE/PHENYLEPHRINE syrup
PROPANTHELINE 15 mg tablet
RYCLORA
RYVENT
scopolamine patch
TENCON
TRANSDERM-SCOP
trihexyphenidyl elixir, tablet
VISTARIL

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

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

Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high risk medication AND
2. Prescriber has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND
3. Prescriber has documented that s/he discussed risks and potential side effects of the requested high risk medication with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **High Risk Medication PA - Carisoprodol**

Drug Name(s):
carisoprodol tablet
carisoprodol/aspirin tablet
carisoprodol/aspirin/codeine tablet
SOMA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested medication AND
2. If patient is 65 years of age or over, then BOTH of the following:
    A. Prescriber has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND
    B. Prescriber has documented that s/he discussed risks and potential side effects of the requested high risk medication with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **High Risk Medication PA - Cyclobenzaprine**

Drug Name(s):
AMRIX
cyclobenzaprine ER capsule
cyclobenzaprine tablet
FEXMID

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested medication AND
2. If patient is 65 years of age or over, then ALL of the following:
    A. ONE of the following:
        i. Patient has fibromyalgia and has tried and failed both duloxetine and Lyrica OR
        ii. Patient has fibromyalgia and has a history of a documented intolerance, FDA labeled contraindication, or hypersensitivity to both duloxetine and Lyrica OR
        iii. Patient has a diagnosis other than fibromyalgia which does NOT require any prerequisites AND
    B. Prescriber has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND
    C. Prescriber has documented that s/he discussed risks and potential side effects of the requested high risk medication with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **High Risk Medication PA - Edluar**

Drug Name(s):
EDLUAR

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
PA does NOT apply to patients less than 65 years of age. Applies to greater than 90 days of therapy per calendar year.

Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high risk medication AND
2. Prescriber has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND
3. Prescriber has documented that s/he discussed risks and potential side effects of the requested high risk medication with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **High Risk Medication PA - Eszopiclone**

Drug Name(s):
eszopiclone tablet
LUNESTA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
PA does NOT apply to patients less than 65 years of age. Applies to greater than 90 days of therapy per calendar year.

Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high risk medication AND
2. Prescriber has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND
3. Prescriber has documented that s/he discussed risks and potential side effects of the requested high risk medication with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group **– High Risk Medication PA - New Starts**

Drug Name(s):
amitriptyline tablet
AMOXAPINE
ANAFRANIL
BRISDELLE
clomipramine capsule
desipramine tablet
doxepin capsule, oral concentrate
imipramine hcl tablet
imipramine pamoate capsule
MEGACE
MEGACE ES
megestrol suspension, tablet
NORPRAMIN
nortriptyline capsule
NORTRIPTYLINE solution
PAMELOR
paroxetine ER tablet
paroxetine tablet
PAXIL
PAXIL CR
PEXEVA
protriptyline tablet
SURMONTIL
TOFRANIL
trimipramine capsule

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only. PA does NOT apply to patients less than 65 years of age.

Criteria for approval require ONE of the following:
1. BOTH of the following:

A. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high risk medication AND
B. There is evidence of a claim that the patient is currently being treated with the requested high risk medication within the past 180 days OR the prescriber states the patient is currently using the requested high risk medication OR

2. ALL of the following:
A. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high risk medication AND
B. Prescriber has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND
C. Prescriber has documented that s/he discussed risks and potential side effects of the requested high risk medication with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **High Risk Medication PA - Orphenadrine**

Drug Name(s):
orphenadrine ER tablet
orphenadrine injection

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested medication AND
2. If patient is 65 years of age or over, then BOTH of the following:
    A. Prescriber has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND
    B. Prescriber has documented that s/he discussed risks and potential side effects of the requested high risk medication with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **High Risk Medication PA - Zaleplon**

Drug Name(s):
SONATA
zaleplon capsule

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
PA does NOT apply to patients less than 65 years of age. Applies to greater than 90 days of therapy per calendar year.

Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high risk medication AND
2. Prescriber has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND
3. Prescriber has documented that s/he discussed risks and potential side effects of the requested high risk medication with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **High Risk Medication PA - Zolpidem**

Drug Name(s):
AMBIEN
zolpidem tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
PA does NOT apply to patients less than 65 years of age. Applies to greater than 90 days of therapy per calendar year.

Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high risk medication AND
2. Prescriber has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND
3. Prescriber has documented that s/he discussed risks and potential side effects of the requested high risk medication with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **High Risk Medication PA - Zolpidem ER**

Drug Name(s):
AMBIEN CR
zolpidem ER tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
PA does NOT apply to patients less than 65 years of age. Applies to greater than 90 days of therapy per calendar year.

Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high risk medication AND
2. Prescriber has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND
3. Prescriber has documented that s/he discussed risks and potential side effects of the requested high risk medication with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **High Risk Medication PA - Zolpidem Sublingual**

Drug Name(s):
INTERMEZZO
zolpidem sublingual tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
PA does NOT apply to patients less than 65 years of age. Applies to greater than 90 days of therapy per calendar year.

Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high risk medication AND
2. Prescriber has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND
3. Prescriber has documented that s/he discussed risks and potential side effects of the requested high risk medication with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **HoFH PA - Juxtapid**

Drug Name(s):
JUXTAPID

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) AND
2. ONE of the following:
    A. Genetic confirmation of two mutant alleles at the LDLR, Apo-B, PCSK9, ARH adaptor protein 1/LDLRAP1 gene locus OR
    B. Untreated LDL-C greater than 500 mg/dL (greater than 13 mmol/L) or treated LDL-C 300 mg/dL or greater (7.76 mmol/L or greater) with ONE of the following:
        i. Patient had cutaneous or tendon xanthoma before age 10 years OR
        ii. Untreated elevated cholesterol levels consistent with heterozygous FH in both parents [untreated total cholesterol greater than 290 mg/dL (greater than 7.5 mmol/L) or untreated LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L)] AND
3. ONE of the following:
    A. Patient is on a maximally tolerated lipid-lowering regimen in the last 90 days (i.e. rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe) OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a maximally tolerated lipid-lowering regimen (i.e. rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe) AND
4. Prescriber has taken baseline lab values for LDL-C, Apo-B, total cholesterol (TC), Non-HDL-C, and triglycerides (TG) AND
5. The requested agent will NOT be used in combination with Kynamro (mipomersen)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Criteria for renewal require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) AND
3. Patient has shown a reduction from baseline in at least ONE of the following metrics:
    A. LDL-C OR
    B. Apo-B OR
    C. Total cholesterol (TC) OR
    D. Non-HDL-C OR
    E. Triglycerides (TG) AND
4. ONE of the following:
    A. Patient is on a maximally tolerated lipid-lowering regimen in the last 90 days (i.e. rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe) OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a maximally tolerated lipid-lowering regimen (i.e. rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe) AND
5. The requested agent will NOT be used in combination with Kynamro (mipomersen)

Prior Authorization Group – **HoFH PA - Kynamro**

Drug Name(s):
KYNAMRO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) AND
2. ONE of the following:
    A. Genetic confirmation of two mutant alleles at the LDLR, Apo-B, PCSK9, ARH adaptor protein 1/LDLRAP1 gene locus OR
    B. Untreated LDL-C greater than 500 mg/dL (greater than 13 mmol/L) or treated LDL-C 300 mg/dL or greater (7.76 mmol/L or greater) with ONE of the following:
        i. Patient had cutaneous or tendon xanthoma before age 10 years OR
        ii. Untreated elevated cholesterol levels consistent with heterozygous FH in both parents [untreated total cholesterol greater than 290 mg/dL (greater than 7.5 mmol/L) or untreated LDL-C greater than190 mg/dL (greater than 4.9 mmol/L)] AND
3. ONE of the following:
    A. Patient is on a maximally tolerated lipid-lowering regimen in the last 90 days (i.e. rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe) OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a maximally tolerated lipid-lowering regimen (i.e. rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe) AND
4. Prescriber has taken baseline lab values for LDL-C, Apo-B, total cholesterol (TC), Non-HDL-C, and triglycerides (TG) AND
5. The requested agent will NOT be used in combination with Juxtapid (lomitapide)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Initial approval 6 months. Renewal approval 12 months.

Other Criteria:

Criteria for renewal require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) AND
3. Patient has shown a reduction from baseline in at least ONE of the following metrics:
    A. LDL-C OR
    B. Apo-B OR
    C. Total cholesterol (TC) OR
    D. Non-HDL-C OR
    E. Triglycerides (TG) AND
4. ONE of the following:
    A. Patient is on a maximally tolerated lipid-lowering regimen in the last 90 days (i.e. rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe) OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a maximally tolerated lipid-lowering regimen (i.e. rosuvastatin in combination with ezetimibe OR atorvastatin in combination with ezetimibe) AND
5. The requested agent will NOT be used in combination with Juxtapid (lomitapide)

Prior Authorization Group – **Ilaris PA**

Drug Name(s):
ILARIS

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D, plus the off-label use for acute gouty arthritis.

Exclusion Criteria:
An active or chronic infection (e.g. tuberculosis, HIV, hepatitis B/C)

Required Medical:
Criteria for approval require BOTH of:
1. ONE of:
    A. Patient (pt) has been diagnosed with Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) OR
    B. Pt has been diagnosed with Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD) OR
    C. Pt has been diagnosed with Familial Mediterranean Fever (FMF) AND ONE of:
        i. Pt has tried and failed colchicine OR
        ii. Pt has a documented intolerance, FDA labeled contraindication, or hypersensitivity to colchicine OR
    D. Pt has been diagnosed with Cryopyrin-Associated Periodic Syndrome (CAPS) including Familial Cold Auto-inflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS) AND pt is at least 4 years of age OR
    E. Pt has been diagnosed with systemic juvenile idiopathic arthritis (SJIA) AND ALL of:
        i. Pt is at least 2 years of age AND
        ii. Pt has documented active systemic features (e.g. ongoing fever, anemia, rash, C-Reactive Protein levels greater than 50 mg/L, 2 or more joints with active arthritis) AND
        iii. ONE of:
            a. Pt has tried and failed at least ONE prerequisite agent (oral or IV glucocorticosteroids, prescription oral NSAIDs, methotrexate, leflunomide, Humira) OR
            b. Pt has a documented intolerance, FDA labeled contraindication, or hypersensitivity to at least ONE prerequisite agent OR
    F. Pt has been diagnosed with acute gouty arthritis AND BOTH of:
        i. Pt is at least 18 years of age AND
        ii. ONE of:

a. Pt has tried and failed at least TWO conventional first-line agents (prescription oral NSAIDs, colchicine, systemic corticosteroids) OR
b. Pt has a documented intolerance, FDA labeled contraindication, or hypersensitivity to at least TWO conventional first-line agents AND

2. ONE of:
   A. Pt is NOT currently being treated with another biologic agent OR
   B. Pt is currently being treated with another biologic agent and the agent will be discontinued prior to initiating the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Imiquimod PA**

Drug Name(s):
ALDARA
imiquimod 5% cream

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
This program applies to new starts only.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently using the requested agent OR
    c. Patient has ONE of the following diagnoses:
        i. Actinic keratosis OR
        ii. Superficial basal cell carcinoma
        iii. External genital and/or perianal warts/condyloma acuminata OR
        iv. Squamous cell carcinoma OR
        v. Basal cell carcinoma OR
        vi. Another indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
4 months for Actinic keratosis, other diagnoses - see Other Criteria

Other Criteria:
2 months for Superficial basal cell carcinoma, Squamous cell carcinoma, and Basal cell carcinoma

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

12 months for All other diagnoses

Prior Authorization Group – **Inbrija PA**

Drug Name(s):
INBRIJA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require ALL of the following:
1. The requested agent will be used for intermittent treatment of OFF episodes in patients with Parkinson's disease AND
2. Patient is receiving concurrent therapy with carbidopa/levodopa within the past 30 days AND
3. Patient is not currently taking a nonselective monoamine oxidase (MAO) inhibitor (e.g., phenelzine, tranylcypromine) or the patient has not recently (within 2 weeks) taken a nonselective MAO inhibitor

Age Restrictions:

Prescriber Restrictions:
Prescriber is a neurologist or the prescriber has consulted with a neurologist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Ingrezza PA**

Drug Name(s):
INGREZZA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of tardive dyskinesia AND
2. ONE of the following:
    A. The prescriber has reduced the dose of or discontinued any medications known to cause tardive dyskinesia (i.e., dopamine receptor blocking agents) OR
    B. The prescriber has provided clinical rationale indicating that a reduced dose or discontinuation of the offending agent is not appropriate

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

***Prior Authorization Group* – Injectable Oncology PA**

Drug Name(s):

ABRAXANE
ALIMTA
ALIQOPA
ARZERRA
AVASTIN
BELEODAQ
BESPONSA
BLINCYTO
BORTEZOMIB
CYRAMZA
DARZALEX
DOXIL
doxorubicin liposomal injection
EMPLICITI
ERBITUX
FOLOTYN
GAZYVA
HALAVEN
HERCEPTIN
HERCEPTIN HYLECTA
INFUGEM
ISTODAX
JEVTANA
KADCYLA
KANJINTI
KYPROLIS
LARTRUVO
LUMOXITI
MVASI
MYLOTARG
ONIVYDE
PERJETA
POLIVY
PORTRAZZA
POTELIGEO
ROMIDEPSIN
SYNRIBO
UNITUXIN

VECTIBIX
VELCADE
VYXEOS
YONDELIS
ZALTRAP

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
This program applies to new starts only.
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. Patient has tried and failed the first line agent for the intended indication (if applicable) OR
            b. Patient a documented intolerance, FDA labeled contraindication, or hypersensitivity to the first line agent AND
        iii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent AND
        iv. Patient does NOT have any FDA labeled limitation(s) of use that is not otherwise supported in NCCN guidelines

May also be subject to Part B versus Part D review.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **IPF PA - Esbriet**

Drug Name(s):
ESBRIET

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF) AND
2. Patient has no known explanation for interstitial lung disease (ILD) or pulmonary fibrosis (e.g. radiation, drugs, metal dusts, sarcoidosis, or any connective tissue disease known to cause ILD) AND
3. ONE of the following:
    A. Patient is NOT currently treated with Ofev (nintedanib) within the past 90 days OR
    B. Patient has been treated with Ofev (nintedanib) within the past 90 days AND therapy will be discontinued prior to starting therapy with the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF) AND
3. The requested agent has been clinically beneficial to the patient AND
4. ONE of the following:
    A. Patient is NOT currently treated with Ofev (nintedanib) within the past 90 days OR
    B. Patient has been treated with Ofev (nintedanib) within the past 90 days AND therapy will be discontinued prior to starting therapy with the requested agent

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. pulmonologist, radiologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **IPF PA - Ofev**

Drug Name(s):
OFEV

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF) AND
2. Patient has no known explanation for interstitial lung disease (ILD) or pulmonary fibrosis (e.g. radiation, drugs, metal dusts, sarcoidosis, or any connective tissue disease known to cause ILD) AND
3. ONE of the following:
    A. Patient is NOT currently treated with Esbriet (pirfenidone) within the past 90 days OR
    B. Patient has been treated with Esbriet (pirfenidone) within the past 90 days AND therapy will be discontinued prior to starting therapy with the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF) AND
3. The requested agent has been clinically beneficial to the patient AND
4. ONE of the following:
    A. Patient is NOT currently treated with Esbriet (pirfenidone) within the past 90 days OR
    B. Patient has been treated with Esbriet (pirfenidone) within the past 90 days AND therapy will be discontinued prior to starting therapy with the requested agent

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. pulmonologist, radiologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Iron Chelating Agents PA - Exjade**

Drug Name(s):
deferasirox tablet
EXJADE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ONE of the following:
a. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome AND ONE of the following:
    i. A liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight OR
    ii. A serum ferritin greater than 300 mcg/L OR
    iii. MRI confirmation of iron deposition OR
b. Patient has a diagnosis of chronic iron overload due to blood transfusions

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. ONE of the following:
    a. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome OR
    b. Patient has a diagnosis of chronic iron overload due to blood transfusions AND
3. Patient has shown clinical benefit with the requested agent

Age Restrictions:
For diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome, patient is at least 10 years of age. For diagnosis of chronic iron overload due to blood transfusions, patient is at least 2 years of age.

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Iron Chelating Agents PA - Jadenu**

Drug Name(s):
JADENU
JADENU SPRINKLE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ONE of the following:
a. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome AND ONE of the following:
    i. A liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight OR
    ii. A serum ferritin greater than 300 mcg/L OR
    iii. MRI confirmation of iron deposition OR
b. Patient has a diagnosis of chronic iron overload due to blood transfusions

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. ONE of the following:
    a. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome OR
    b. Patient has a diagnosis of chronic iron overload due to blood transfusions AND
3. Patient has shown clinical benefit with the requested agent

Age Restrictions:
For diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome, patient is at least 10 years of age. For diagnosis of chronic iron overload due to blood transfusions, patient is at least 2 years of age.

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Jynarque PA**

Drug Name(s):
JYNARQUE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of autosomal dominant polycystic kidney disease confirmed by ONE of the following:
    a. Ultrasound OR
    b. MRI or CT scan OR
    c. Genetic testing AND
2. Patient is at risk of rapid disease progression AND
3. ONE of the following:
    a. Patient is initiating therapy AND BOTH of the following:
        i. Patient's ALT, AST, and bilirubin have been measured AND
        ii. The ALT, AST, and bilirubin levels are under the upper limit of normal (ULN) OR
    b. BOTH of the following:
        i. Patient is continuing therapy AND
        ii. Patient will continue to receive routine ALT, AST, and bilirubin monitoring at least every 3 months

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's prior authorization criteria AND
2. Patient has a diagnosis of autosomal dominant polycystic kidney disease AND
3. Prescriber has indicated that the patient has shown clinical benefit with the requested agent AND
4. Patient will continue to receive routine ALT, AST, and bilirubin monitoring at least every 3 months

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. nephrologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Kalydeco PA**

Drug Name(s):
KALYDECO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. Patient has ONE of the CFTR gene mutations as indicated in the FDA label as confirmed by genetic testing AND
3. Patient is NOT homozygous for the F508del mutation AND
4. Patient has had pre-therapeutic/baseline FEV1 levels measured AND
5. ONE of the following:
    A. Patient is NOT currently being treated with another CFTR agent [e.g. Orkambi (lumacaftor/ivacaftor), Symdeko (tezacaftor/ivacaftor and ivacaftor)] OR
    B. Patient is currently being treated with another CFTR agent AND will discontinue the other CFTR agent prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of cystic fibrosis AND
3. Patient has shown improvement or stabilization in FEV1 from pretreatment levels with the requested agent AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another CFTR agent [e.g. Orkambi (lumacaftor/ivacaftor), Symdeko (tezacaftor/ivacaftor and ivacaftor)] OR
    B. Patient is currently being treated with another CFTR agent AND will discontinue the other CFTR agent prior to starting the requested agent

Age Restrictions:
Patient is 6 months of age or over

Prescriber Restrictions:
Prescriber is a specialist (e.g. cystic fibrosis, pulmonologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Keveyis PA**

Drug Name(s):
KEVEYIS

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require the following:
1. Patient has a diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, or a related variant

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Korlym PA**

Drug Name(s):
KORLYM

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of Cushing's syndrome AND
2. ONE of the following:
    A. Patient has type 2 diabetes mellitus OR
    B. Patient has glucose intolerance (defined as 2-hour glucose tolerance test with glucose value of 140-199 mg/dL) AND
3. ONE of the following:
    A. Patient has failed surgical resection OR
    B. Patient is not a candidate for surgical resection

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Kuvan PA**

Drug Name(s):
KUVAN

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of phenylketonuria (PKU) AND
2. Prescriber has submitted a baseline blood Phe level measured prior to initiation of therapy with the requested agent, which is above the recommended levels indicated for the patient's age range or condition AND
3. The dose is within FDA labeling

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of phenylketonuria (PKU) AND
3. ONE of the following:
    a. Patient's blood Phe levels are being maintained within the acceptable range OR
    b. Patient has had a decrease in blood Phe level from baseline AND
4. The dose is within FDA labeling

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist with knowledge and expertise in metabolic diseases or genetic diseases or has consulted with a specialist in metabolic or genetic diseases

Coverage Duration:
Initial: 2 months if dose is 5 to less than 20 mg/kg/day, 1 month if 20 mg/kg/day
Renewal: 12 months

Other Criteria:

Prior Authorization Group – **Lidocaine Topical PA - Lidocaine Gel/Jelly**

Drug Name(s):
lidocaine 2% gel

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require the following:
1. The requested agent will be used for ONE of the following:
    A. Surface anesthesia and lubrication for urethral procedure OR
    B. Topical treatment for pain of urethritis OR
    C. Surface anesthesia and lubrication for endotracheal intubation (oral and nasal) OR
    D. Another indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Lidocaine Topical PA - Lidocaine Ointment**

Drug Name(s):
lidocaine 5% ointment

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require the following:
1. The requested agent will be used for ONE of the following:
    A. Anesthesia of accessible mucous membranes of the oropharynx OR
    B. Anesthetic lubricant for intubation OR
    C. Temporary relief of pain associated with minor burns, including sunburn, abrasions of the skin, and insect bites OR
    D. Another indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Lidocaine Topical PA - Lidocaine Patch**

Drug Name(s):
lidocaine 5% transdermal patch
LIDODERM

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require the following:
1. Patient has ONE of the following diagnoses:
    A. Pain associated with postherpetic neuralgia (PHN) OR
    B. Pain associated with diabetic neuropathy OR
    C. Neuropathic pain associated with cancer OR
    D. Another diagnosis that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Lidocaine Topical PA - Lidocaine Solution**

Drug Name(s):
lidocaine 4% solution

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require the following:
1. The requested agent will be used for ONE of the following:
    A. Topical anesthesia of accessible mucous membranes of the oral and nasal cavities OR
    B. Topical anesthesia of accessible mucous membranes of proximal portions of the digestive tract OR
    C. Another indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Lidocaine Topical PA - Lidocaine/prilocaine Cream**

Drug Name(s):
lidocaine/prilocaine 2.5-2.5% cream

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require the following:
1. The requested agent will be used for ONE of the following:
    A. Local analgesia on normal intact skin OR
    B. Topical anesthetic for dermal procedures OR
    C. Adjunctive anesthesia prior to local anesthetic infiltration in adult male genital skin OR
    D. Anesthesia for minor procedures on female external genitalia OR
    E. Another indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Lidocaine Topical PA - ZTlido**

Drug Name(s):
ZTLIDO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has ONE of the following diagnoses:
    A. Pain associated with postherpetic neuralgia (PHN) OR
    B. Neuropathic pain associated with cancer, or cancer treatment OR
    C. Another diagnosis that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. Patient's medication history includes use of generic lidocaine 5% patches OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to generic lidocaine 5% patches

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Linezolid PA**

Drug Name(s):
linezolid suspension, tablet
ZYVOX suspension, tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. ONE of the following:
    a. The requested agent is prescribed by an infectious disease specialist or the prescriber has consulted with an infectious disease specialist on treatment of this patient AND the patient has an FDA labeled indication for the requested agent OR
    b. Patient has a documented infection due to vancomycin-resistant Enterococcus faecium OR
    c. Patient has a diagnosis of pneumonia caused by Staphylococcus aureus or Streptococcus pneumoniae AND ONE of the following:
        i. Patient has a documented infection that is resistant to beta lactams, macrolides, clindamycin, tetracycline, and co-trimoxazole OR that is resistant to vancomycin OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to beta lactams, macrolides, clindamycin, tetracyclines, and co-trimoxazole OR
        iii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to vancomycin OR
    d. Patient has a documented skin and skin structure infection, including diabetic foot infections, caused by Staphylococcus aureus, Streptococcus pyogenes, or Streptococcus agalactiae AND ONE of the following:
        i. Patient has a documented infection that is resistant to beta lactams, macrolides, clindamycin, tetracycline, and co-trimoxazole OR that is resistant to vancomycin at the site of infection OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to beta lactams, macrolides, clindamycin, tetracyclines, and co-trimoxazole OR
        iii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to vancomycin AND

2. ONE of the following:
    a. Patient is NOT currently being treated for the same infection with Sivextro (tedizolid) OR
    b. Current treatment with Sivextro (tedizolid) for the same infection will be discontinued before starting therapy with the requested agent AND
3. The dose is within the FDA labeled dosage

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 3 months

Other Criteria:

Prior Authorization Group – **Linzess PA**

Drug Name(s):
LINZESS

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has ONE of the following diagnoses:
    A. Chronic idiopathic constipation with documentation of symptoms for at least 3 months OR
    B. Irritable bowel syndrome with constipation with documentation of symptoms for at least 3 months AND
2. ONE of the following:
    A. Patient has a medication history that includes lactulose or polyethylene glycol 3350 OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to lactulose or polyethylene glycol 3350

Age Restrictions:
Patient is 18 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Mavyret PA**

Drug Name(s):
MAVYRET

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The dosing of the requested agent is within the FDA labeled dosing or is AASLD/IDSA guideline supported AND
5. ONE of the following:
    A. There is documentation that the patient is currently being treated with the requested agent OR
    B. Patient has an FDA labeled contraindication or hypersensitivity to the preferred agents: Harvoni (ledipasvir/sofosbuvir) for supported genotypes OR Epclusa (sofosbuvir/velpatasvir) for genotype 2 or 3 OR
    C. Prescriber has submitted documentation based on FDA approved labeling or AASLD/IDSA guidelines to support the use of the non-preferred agent for the patient's diagnosis and genotype over the preferred agents: Harvoni (ledipasvir/sofosbuvir) for supported genotypes OR Epclusa (sofosbuvir/velpatasvir) for genotype 2 or 3

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist

Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported

Other Criteria:

Prior Authorization Group – **Memantine ER PA**

Drug Name(s):
NAMENDA XR
NAMENDA XR TITRATION PAK

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
PA does NOT apply to patients 30 years of age or over

Criteria for approval require ONE of the following:
A. Patient has a diagnosis of moderate to severe dementia of the Alzheimer's type OR
B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Memantine PA**

Drug Name(s):
memantine ER capsule
memantine solution, tablet
memantine titration pak
NAMENDA
NAMENDA TITRATION PAK

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
PA does NOT apply to patients 30 years of age or over

Criteria for approval require ONE of the following:
A. Patient has a diagnosis of moderate to severe dementia of the Alzheimer's type OR
B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Methamphetamine PA**

Drug Name(s):
DESOXYN
methamphetamine 5 mg tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
Requested agent will be used to promote weight loss AND FDA labeled contraindication(s) to the requested agent.

Required Medical:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Modafinil PA**

Drug Name(s):
modafinil tablet
PROVIGIL

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. Patient is receiving only one of the listed agents, armodafinil OR modafinil, within the past 90 days OR
    B. Patient has been treated with armodafinil within the past 90 days AND will discontinue prior to starting the requested agent

Age Restrictions:
Patient is 17 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Motegrity PA**

Drug Name(s):
MOTEGRITY

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of chronic idiopathic constipation with documentation of symptoms for at least 3 months AND
2. ONE of the following:
    a. Patient has tried and had an inadequate response to lactulose OR
    b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to lactulose

Age Restrictions:
Patient is 17 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Movantik PA**

Drug Name(s):
MOVANTIK

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has opioid-induced constipation (OIC) and chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment AND
2. Patient has chronic use of an opioid agent in the past 90 days AND
3. ONE of the following:
    A. Patient has a medication history that includes lactulose or polyethylene glycol 3350 OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to lactulose or polyethylene glycol 3350

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **MS PA - Aubagio**

Drug Name(s):
AUBAGIO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient is NOT currently being treated with a disease modifying agent (DMA) other than the requested agent OR
    B. Patient is currently being treated with a DMA other than the requested agent AND the DMA will be discontinued before starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient is NOT currently being treated with an additional disease modifying agent (DMA) for the intended FDA labeled indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **MS PA - Avonex**

Drug Name(s):
AVONEX
AVONEX PREFILLED KIT

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient is NOT currently being treated with a disease modifying agent (DMA) other than the requested agent OR
    B. Patient is currently being treated with a DMA other than the requested agent AND the DMA will be discontinued before starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient is NOT currently being treated with an additional disease modifying agent (DMA) for the intended FDA labeled indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **MS PA - Betaseron**

Drug Name(s):
BETASERON
EXTAVIA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient is NOT currently being treated with a disease modifying agent (DMA) other than the requested agent OR
    B. Patient is currently being treated with a DMA other than the requested agent AND the DMA will be discontinued before starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient is NOT currently being treated with an additional disease modifying agent (DMA) for the intended FDA labeled indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **MS PA - Gilenya**

Drug Name(s):
GILENYA 0.5 mg capsule

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient is NOT currently being treated with a disease modifying agent (DMA) other than the requested agent OR
    B. Patient is currently being treated with a DMA other than the requested agent AND the DMA will be discontinued before starting the requested agent AND
3. Prescriber has performed an electrocardiogram within 6 months prior to initiating treatment

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient is NOT currently being treated with an additional disease modifying agent (DMA) for the intended FDA labeled indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **MS PA - Glatiramer**

Drug Name(s):
COPAXONE
glatiramer injection

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient is NOT currently being treated with a disease modifying agent (DMA) other than the requested agent OR
    B. Patient is currently being treated with a DMA other than the requested agent AND the DMA will be discontinued before starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient is NOT currently being treated with an additional disease modifying agent (DMA) for the intended FDA labeled indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **MS PA - Mavenclad**

Drug Name(s):
MAVENCLAD

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient is NOT currently being treated with a disease modifying agent (DMA) other than the requested agent OR
    B. Patient is currently being treated with a DMA other than the requested agent AND the DMA will be discontinued before starting the requested agent AND
3. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently using the requested agent AND is at risk if therapy is changed OR
    C. Patient has a diagnosis of relapsing remitting multiple sclerosis (MS) AND ONE of the following:
        i. Patient's medication history indicates use of at least TWO preferred agents: Aubagio, Avonex, Betaseron, Gilenya, glatiramer (i.e. Copaxone, Glatopa), Mayzent, Plegridy, or Tecfidera OR
        ii. Patient has a documented intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration), FDA labeled contraindication, or hypersensitivity to at least TWO preferred agents: Aubagio, Avonex, Betaseron, Gilenya, glatiramer (i.e. Copaxone, Glatopa), Mayzent, Plegridy, or Tecfidera OR
    D. Patient has a diagnosis of active secondary progressive multiple sclerosis AND ONE of the following:
        i. Patient's medication history indicates use of at least ONE preferred agent: Mayzent OR
        ii. Patient has a documented intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration), FDA labeled contraindication, or hypersensitivity to at least ONE preferred agent: Mayzent AND

4. The dose requested is within the FDA labeled dosing for the requested indication AND
5. The total cumulative duration of treatment with Mavenclad (cladribine) has not exceeded 4 treatment cycles

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
No prior use approve 2 years, Prior use approve remainder of 2 years of total cumulative therapy

Other Criteria:

Prior Authorization Group – **MS PA - Mayzent**

Drug Name(s):
MAYZENT

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient is NOT currently being treated with a disease modifying agent (DMA) other than the requested agent OR
    B. Patient is currently being treated with a DMA other than the requested agent AND the DMA will be discontinued before starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient is NOT currently being treated with an additional disease modifying agent (DMA) for the intended FDA labeled indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **MS PA - Plegridy**

Drug Name(s):
PLEGRIDY
PLEGRIDY STARTER PACK

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient is NOT currently being treated with a disease modifying agent (DMA) other than the requested agent OR
    B. Patient is currently being treated with a DMA other than the requested agent AND the DMA will be discontinued before starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient is NOT currently being treated with an additional disease modifying agent (DMA) for the intended FDA labeled indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **MS PA - Rebif**

Drug Name(s):
REBIF
REBIF REBIDOSE
REBIF REBIDOSE TITRATION PACK
REBIF TITRATION PACK

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient is NOT currently being treated with a disease modifying agent (DMA) other than the requested agent OR
    B. Patient is currently being treated with a DMA other than the requested agent AND the DMA will be discontinued before starting the requested agent AND
3. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently using the requested agent AND is at risk if therapy is changed OR
    C. ONE of the following:
        a. Patient's medication history indicates use of at least TWO preferred agents for MS: Aubagio, Avonex, Betaseron, Gilenya, glatiramer (i.e. Copaxone, Glatopa), Mayzent, Plegridy, or Tecfidera OR
        b. Patient has a documented intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration), FDA labeled contraindication, or hypersensitivity to at least TWO preferred agents: Aubagio, Avonex, Betaseron, Gilenya, glatiramer (i.e. Copaxone, Glatopa), Mayzent, Plegridy, or Tecfidera

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND

3. Patient is NOT currently being treated with an additional disease modifying agent (DMA) for the intended FDA labeled indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **MS PA - Tecfidera**

Drug Name(s):
TECFIDERA
TECFIDERA STARTER PACK

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient is NOT currently being treated with a disease modifying agent (DMA) other than the requested agent OR
    B. Patient is currently being treated with a DMA other than the requested agent AND the DMA will be discontinued before starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient is NOT currently being treated with an additional disease modifying agent (DMA) for the intended FDA labeled indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **MS PA - Tysabri**

Drug Name(s):
TYSABRI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient is NOT currently being treated with a disease modifying agent (DMA) other than the requested agent OR
    B. Patient is currently being treated with a DMA other than the requested agent AND the DMA will be discontinued before starting the requested agent AND
3. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently using the requested agent AND is at risk if therapy is changed OR
    C. Patient has ONE of the following diagnoses:
        i. Multiple sclerosis (MS) AND ONE of the following:
            a. Patient's medication history indicates the use of at least TWO preferred agents for the treatment of MS: Aubagio, Avonex, Betaseron, Gilenya, glatiramer (i.e. Copaxone, Glatopa), Mayzent, Plegridy, or Tecfidera OR
            b. Patient has a documented intolerance, FDA labeled contraindication(s), or hypersensitivity to at least TWO preferred agents for the treatment of MS: Aubagio, Avonex, Betaseron, Gilenya, glatiramer (i.e. Copaxone, Glatopa), Mayzent, Plegridy, or Tecfidera OR
        ii. Crohn's disease (CD) AND BOTH of the following:
            a. ONE of the following:
                1. Patient's medication history indicates the use of at least ONE conventional CD therapy (e.g. aminosalicylates, metronidazole, ciprofloxacin, corticosteroids, methotrexate, or immunomodulators such as azathioprine or 6-mercaptopurine) OR

2. Patient has a documented intolerance, FDA labeled contraindication(s), or hypersensitivity to at least ONE conventional CD therapy AND

b. ONE of the following:

1. Patient's medication history indicates use of ONE preferred biologic agent (Humira or Stelara) for the treatment of CD OR

2. Patient has a documented intolerance, FDA labeled contraindication(s), or hypersensitivity to ONE preferred biologic agent (Humira or Stelara)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months for MS, for CD 16 weeks for initial and 12 months renewal

Other Criteria:

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has shown clinical benefit with the requested agent AND
4. Patient is NOT currently being treated with an additional disease modifying agent (DMA) for the intended FDA labeled indication

Prior Authorization Group – **Mulpleta PA**

Drug Name(s):
MULPLETA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require ALL of the following:
1. Patent has a diagnosis of thrombocytopenia AND
2. Patient has chronic liver disease AND
3. Patient has a platelet count less than 50 X 109/L AND
4. Patient is scheduled to undergo a procedure with an associated risk of bleeding (e.g. gastrointestinal endoscopy, liver biopsy, bronchoscopy, dental procedure) AND
5. The dosing of the requested agent is within the FDA labeled dosing AND
6. The length of therapy of the requested agent is within the FDA labeled duration

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 1 month

Other Criteria:

Prior Authorization Group – **Myalept PA**

Drug Name(s):
MYALEPT

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of either congenital generalized lipodystrophy (CGL) or acquired generalized lipodystrophy (AGL) AND
2. Prescriber has drawn baseline values for HbA1C, triglycerides, and fasting insulin prior to beginning therapy with the requested agent AND
3. Patient also has at least ONE of the following additional diagnosis: diabetes mellitus, hypertriglyceridemia (200 mg/dL or higher), and/or high fasting insulin (30µU/mL or higher) AND
4. Patient has failed maximum tolerable dosing of a conventional agent for the additional diagnosis within the past 90 days AND
5. The dose is within the FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of either congenital generalized lipodystrophy (CGL) or acquired generalized lipodystrophy (AGL) AND
3. Patient has had a reduction in at least ONE of the following parameters: HbA1C, triglycerides and/or fasting insulin from baseline levels drawn prior to initiating the requested agent AND
4. The dose is within the FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. endocrinologist, cardiologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Conventional agent examples include:
Hypertriglyceridemia: statins, fenofibrates, Omega-3-Acid Ethyl Esters (generic Lovaza)
Diabetes/high fasting insulin: insulin, sulfonylurea/sulfonylurea combination, metformin/metformin combination

Prior Authorization Group – **Natpara PA**

Drug Name(s):
NATPARA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
Increased baseline risk for osteosarcoma

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of hypocalcemia with hypoparathyroidism AND
2. Prescriber has confirmed the patient's 25-hydroxyvitamin D stores are not below the testing laboratory's normal range AND
3. Prescriber has confirmed the patient's serum calcium is above 7.5 mg/dL AND
4. ONE of the following:
    A. Patient is NOT on concomitant use of alendronate OR
    B. Patient is currently on alendronate and will discontinue it prior to therapy with the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of hypocalcemia with hypoparathyroidism AND
3. Patient has shown clinical benefit with the requested agent AND
4. Patient has an albumin-corrected total serum calcium concentration between 7.5 mg/dL and 10.6 mg/dL AND
5. ONE of the following:
    A. Patient is NOT on concomitant use of alendronate OR
    B. Patient is currently on alendronate and will discontinue it prior to therapy with the requested agent

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. endocrinologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Nocdurna PA**

Drug Name(s):
NOCDURNA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of nocturia due to nocturnal polyuria (awakening at least two times per night to void) AND
2. Diagnosis was confirmed by a nighttime urine production greater than one third of 24-hour urine collection AND
3. Prescriber has confirmed that the patient's serum sodium concentration is within normal range [between 135 to 145 mEq/L (mmol/L) or within testing laboratory's normal range]

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Noctiva PA**

Drug Name(s):
NOCTIVA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of nocturia due to nocturnal polyuria (awakening at least two times per night to void) AND
2. Diagnosis was confirmed by a nighttime urine production greater than one third of 24-hour urine collection AND
3. Prescriber has confirmed that the patient's serum sodium concentration is within normal range [between 135 to 145 mEq/L (mmol/L) or within testing laboratory's normal range]

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's prior authorization criteria AND
2. Patient has a diagnosis of nocturia due to nocturnal polyuria (awakening at least two times per night to void) AND
3. Prescriber has confirmed that the patient's serum sodium concentration is within normal range [between 135 to 145 mEq/L (mmol/L) or within testing laboratory's normal range] AND
4. Patient has shown clinical benefit with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Northera PA**

Drug Name(s):
NORTHERA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of neurogenic orthostatic hypotension (NOH) AND
2. Prescriber has performed baseline blood pressure readings while the patient is sitting or supine (lying face up), AND also within 3 minutes of standing from a supine position AND
3. Patient has a decrease of at least 20 mmHg in systolic blood pressure or 10 mmHg diastolic blood pressure within 3 minutes after standing AND
4. Patient has persistent and consistent symptoms of neurogenic orthostatic hypotension (NOH) caused by ONE of the following:
    A. Primary autonomic failure [Parkinson's disease (PD), multiple system atrophy, or pure autonomic failure] OR
    B. Dopamine beta-hydroxylase deficiency OR
    C. Non-diabetic autonomic neuropathy AND
5. Prescriber has assessed the severity of the patient's baseline symptoms of dizziness, lightheadedness, feeling faint, or feeling like the patient may black out

Criteria for renewal require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of neurogenic orthostatic hypotension (NOH) AND
3. Patient has demonstrated improvement in severity from baseline symptoms of dizziness, lightheadedness, feeling faint, or feeling like the patient may black out AND
4. Patient had an increase in systolic blood pressure from baseline of at least 10 mmHg upon standing from a supine (laying face up) position

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. cardiologist, neurologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be 1 month for initial, 3 months for renewal

Other Criteria:

Prior Authorization Group – **Noxafil PA**

Drug Name(s):
NOXAFIL injection, suspension
posaconazole 100 mg delayed release tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ONE of the following:
A. Patient has a diagnosis of oropharyngeal candidiasis AND patient has tried fluconazole or an alternative antifungal agent OR patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to fluconazole or an alternative antifungal agent OR
B. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida AND patient is severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR
C. Patient has a diagnosis of invasive Aspergillus AND patient has tried an alternative antifungal agent OR patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to an alternative antifungal agent OR
D. Patient has another indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
One month for oropharyngeal candidiasis, 6 months for other indications

Other Criteria:
Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. ONE of the following:

A. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida and patient continues to be severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR
B. Patient has a diagnosis of invasive Aspergillus AND patient has continued indicators of active disease (e.g. continued radiologic findings, positive cultures, positive serum galactomannan assay for Aspergillus) OR
C. Patient has another indication that is supported in CMS approved compendia for the requested agent

Prior Authorization Group – **Nucala PA**

Drug Name(s):
NUCALA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of:
1. ONE of:
    A. Patient (pt) has diagnosis (dx) of severe eosinophilic asthma AND ALL of:
        i. Pt's dx has been confirmed by ONE of the following eosinophilic counts:
            1. Blood eosinophilic count greater than or equal to 150 cells/microliter prior to initiation (within previous 6 weeks) of therapy with requested agent OR
            2. Blood eosinophilic count greater than or equal to 300 cells/microliter within previous 12 months OR
            3. Sputum eosinophilic count greater than 3% AND
        ii. Pt has a baseline Forced Expiratory Volume (FEV1) that is less than 80% of predicted AND
        iii. Pt has ONE of:
            1. Frequent severe asthma exacerbations requiring two or more courses of systemic corticosteroids (steroid burst) within past 12 months OR
            2. Serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to emergency room or urgent care within past 12 months OR
            3. Controlled asthma that worsens when doses of inhaled or systemic corticosteroids are tapered AND
        iv. ONE of:
            1. There is evidence of a claim within past 90 days that pt is currently being treated with a maximally tolerated inhaled corticosteroid OR
            2. Pt has a documented intolerance, FDA labeled contraindication, or hypersensitivity to inhaled corticosteroid AND
        v. ONE of:
            1. There is evidence of a claim within past 90 days that pt is currently being treated with ONE of:
                a. A long-acting beta-2 agonist (LABA) OR

b. A leukotriene receptor antagonist (LRTA) OR
c. Long-acting muscarinic antagonist (LAMA) OR
d. Theophylline OR

2. Pt has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a LABA, LRTA, LAMA, or theophylline OR

B. Pt has dx of eosinophilic granulomatosis with polyangiitis (EGPA) AND BOTH of:

i. Pt's dx of EGPA was confirmed by ONE of:

1. Pt meets 4 of:

a. Asthma (history of wheezing or finding of diffuse high-pitched wheezes on expiration) OR

Initial criteria continues: see Other Criteria

Age Restrictions:

For a diagnosis of severe eosinophilic asthma - Patient is 12 years of age or over

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

b. Greater than 10% eosinophils on differential leukocyte count OR
c. Mononeuropathy (including multiplex) or polyneuropathy OR
d. Migratory or transient pulmonary opacities detected radiographically OR
e. Paranasal sinus abnormality OR
f. Biopsy containing blood vessel showing accumulation of eosinophils in extravascular areas OR

2. Pt meets ALL of:

a. Asthma AND
b. Peak peripheral blood eosinophilia greater than 1500 cells/microliter AND
c. Systemic vasculitis involving two or more extra-pulmonary organs AND

ii. ONE of:

1. There is evidence of a claim within past 90 days that pt is currently being treated with a maximally tolerated oral corticosteroid OR

2. Pt has a documented intolerance, FDA labeled contraindication, or hypersensitivity to oral corticosteroid AND

2. Pt will NOT receive the requested agent in combination with Xolair or with another interleukin 5 (IL-5) inhibitor for the requested indication (e.g. Cinqair, Fasenra) AND
3. The dose requested is within FDA labeled dosing

Criteria for renewal approval require ALL of:
1. Pt has been previously approved for requested agent through plan's PA criteria AND
2. ONE of:
    A. Pt has a dx of severe eosinophilic asthma AND BOTH of:
        i. Pt has had clinical response or disease stabilization as defined by ONE of:
            1. Increase in percent predicated Forced Expiratory Volume (FEV1) from baseline OR
            2. Decrease in dose of inhaled corticosteroids required to control pt's asthma OR
            3. Decrease in need for treatment with systemic corticosteroids due to exacerbations of asthma OR
            4. Decrease in number of hospitalizations, need for mechanical ventilation, or visits to urgent care or emergency room due to exacerbations of asthma AND
        ii. ONE of:
            1. There is evidence of a claim within past 90 days that pt is being treated with standard therapy (e.g. inhaled corticosteroids, LABA, LRTA, LAMA, theophylline) OR
            2. Pt has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a standard therapy OR
    B. Pt has a dx of eosinophilic granulomatosis with polyangiitis (EGPA) AND BOTH of:
        i. Pt has had clinical response or disease stabilization as defined by ONE of:
            1. Remission achieved with the requested agent OR
            2. Decrease in corticosteroid maintenance dose required for control of symptoms related to EGPA OR
            3. Decrease in hospitalization due to symptoms of EGPA AND
        ii. ONE of:
            1. There is evidence of a claim within past 90 days that pt is being treated with maintenance therapy with oral corticosteroid OR
            2. Pt has a documented intolerance, FDA labeled contraindication, or hypersensitivity to oral corticosteroid AND
            3. Pt will NOT receive the requested agent in combination with Xolair or with another interleukin 5 (IL-5) inhibitor for the requested indication (e.g. Cinqair, Fasenra) AND
            4. The dose requested is within FDA labeled dosing

Prior Authorization Group – **Nuedexta PA**

Drug Name(s):
NUEDEXTA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of pseudobulbar affect AND
2. Patient is NOT currently receiving a monoamine oxidase inhibitor (MAOI) OR the patient's MAOI will be discontinued at least 14 days prior to starting therapy with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Nuplazid PA**

Drug Name(s):
NUPLAZID

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.

Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Ocaliva PA**

Drug Name(s):
OCALIVA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Primary Biliary Cholangitis (PBC) as evidenced by TWO of the following three criteria at the time of diagnosis:
    A. There is biochemical evidence of cholestasis with an alkaline phosphatase elevation of at least 1.5 times the upper limit of normal
    B. Presence of antimitochondrial antibody (AMA): a titer greater than or equal to 1:40 OR a level that is above the testing laboratory's upper limit of the normal range
    C. Histologic evidence of nonsuppurative destruction cholangitis and destruction of interlobular bile ducts AND
2. Prescriber has documented the patient's baseline (prior to any treatment with the requested agent) alkaline phosphatase (ALP) level AND total bilirubin level AND
3. ONE of the following:
    A. BOTH of the following:
        i. Patient has tried treatment with ursodiol and had an inadequate response AND
        ii. Patient will continue treatment with ursodiol with the requested agent OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ursodiol

Criteria for renewal require ALL of the following:
1. Patient has been previously approved for the requested agent through plan's PA criteria AND
2. Patient has a diagnosis of Primary Biliary Cholangitis (PBC) AND
3. ONE of the following:
    A. Patient is currently on AND will continue treatment with ursodiol with the requested agent OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ursodiol AND

4. Patient has had a decrease in alkaline phosphatase (ALP) level from baseline AND
5. Patient's total bilirubin is less than or equal to the upper limit of normal (ULN)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Oncology Immunotherapy PA - Bavencio**

Drug Name(s):
BAVENCIO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
This program applies to new starts only.
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. Patient has tried and failed the first line agent for the intended indication (if applicable) OR
            b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the first line agent AND
        iii. Patient does NOT have any FDA labeled limitation(s) of use that is not otherwise supported in NCCN guidelines

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Oncology Immunotherapy PA - Imfinzi**

Drug Name(s):
IMFINZI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
This program applies to new starts only.
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. Patient has tried and failed the first line agent for the intended indication (if applicable) OR
            b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the first line agent AND
        iii. Patient does NOT have any FDA labeled limitation(s) of use that is not otherwise supported in NCCN guidelines

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Oncology Immunotherapy PA - Keytruda**

Drug Name(s):
KEYTRUDA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
This program applies to new starts only.
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. Patient has tried and failed the first line agent for the intended indication (if applicable) OR
            b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the first line agent AND
        iii. Patient does NOT have any FDA labeled limitation(s) of use that is not otherwise supported in NCCN guidelines

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Oncology Immunotherapy PA - Libtayo**

Drug Name(s):
LIBTAYO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
This program applies to new starts only.
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. Patient has tried and failed the first line agent for the intended indication (if applicable) OR
            b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the first line agent AND
        iii. Patient does NOT have any FDA labeled limitation(s) of use that is not otherwise supported in NCCN guidelines

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Oncology Immunotherapy PA - Opdivo**

Drug Name(s):
OPDIVO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
This program applies to new starts only.
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. Patient has tried and failed the first line agent for the intended indication (if applicable) OR
            b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the first line agent AND
        iii. Patient does NOT have any FDA labeled limitation(s) of use that is not otherwise supported in NCCN guidelines

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Oncology Immunotherapy PA - Tecentriq**

Drug Name(s):
TECENTRIQ

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
This program applies to new starts only.
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. Patient has tried and failed the first line agent for the intended indication (if applicable) OR
            b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the first line agent AND
        iii. Patient does NOT have any FDA labeled limitation(s) of use that is not otherwise supported in NCCN guidelines

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Oncology Immunotherapy PA - Yervoy**

Drug Name(s):
YERVOY

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
This program applies to new starts only.
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. ONE of the following:
            a. Patient has tried and failed the first line agent for the intended indication (if applicable) OR
            b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the first line agent AND
        iii. Patient does NOT have any FDA labeled limitation(s) of use that is not otherwise supported in NCCN guidelines

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Ophthalmic Immunomodulators PA - Cequa**

Drug Name(s):
CEQUA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has an FDA labeled indication for the requested agent OR
2. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Ophthalmic Immunomodulators PA - Restasis**

Drug Name(s):
RESTASIS
RESTASIS MULTIDOSE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has an FDA labeled indication for the requested agent OR
2. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Ophthalmic Immunomodulators PA - Xiidra**

Drug Name(s):
XIIDRA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Opioids ER PA - Buprenorphine Pain**

Drug Name(s):

BELBUCA
buprenorphine transdermal patch
BUTRANS

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:

Program applies to new starts only.
Criteria for approval require ONE of the following:
A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
B. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
    i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    ii. Prescriber states the patient is currently using the requested agent within the past 180 days OR
C. Patient is undergoing treatment of chronic non-cancer pain AND ALL of the following:
    i. Prescriber provides documentation of a formal, consultative evaluation including:
        1. Diagnosis AND
        2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
    ii. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
    iii. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
    iv. ONE of the following:
        1. Patient's medication history includes use of an immediate-acting opioid OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to immediate-acting opioid AND
    v. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Opioids ER PA - Fentanyl Patch**

Drug Name(s):
DURAGESIC
fentanyl transdermal patch

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.
Criteria for approval require ONE of the following:
A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
B. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
    i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    ii. Prescriber states the patient is currently using the requested agent within the past 180 days OR
C. Patient is undergoing treatment of chronic non-cancer pain AND ALL of the following:
    i. Prescriber provides documentation of a formal, consultative evaluation including:
        1. Diagnosis AND
        2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
    ii. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
    iii. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
    iv. ONE of the following:
        1. Patient's medication history includes use of an immediate-acting opioid OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to immediate-acting opioid AND
    v. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Opioids ER PA - Hydrocodone**

Drug Name(s):
HYSINGLA ER
ZOHYDRO ER

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.
Criteria for approval require ONE of the following:
A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
B. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
    i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    ii. Prescriber states the patient is currently using the requested agent within the past 180 days OR
C. Patient is undergoing treatment of chronic non-cancer pain AND ALL of the following:
    i. Prescriber provides documentation of a formal, consultative evaluation including:
        1. Diagnosis AND
        2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
    ii. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
    iii. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
    iv. ONE of the following:
        1. Patient's medication history includes use of an immediate-acting opioid OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to immediate-acting opioid AND
    v. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Opioids ER PA - Hydromorphone**

Drug Name(s):
EXALGO
hydromorphone ER tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.
Criteria for approval require ONE of the following:
A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
B. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
    i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    ii. Prescriber states the patient is currently using the requested agent within the past 180 days OR
C. Patient is undergoing treatment of chronic non-cancer pain AND ALL of the following:
    i. Prescriber provides documentation of a formal, consultative evaluation including:
        1. Diagnosis AND
        2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
    ii. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
    iii. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
    iv. ONE of the following:
        1. Patient's medication history includes use of an immediate-acting opioid OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to immediate-acting opioid AND
    v. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Opioids ER PA - Morphine**

Drug Name(s):

EMBEDA
KADIAN
MORPHABOND ER
morphine sulfate ER tablet, capsule
MS CONTIN

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:

Program applies to new starts only.
Criteria for approval require ONE of the following:
A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
B. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
    i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    ii. Prescriber states the patient is currently using the requested agent within the past 180 days OR
C. Patient is undergoing treatment of chronic non-cancer pain AND ALL of the following:
    i. Prescriber provides documentation of a formal, consultative evaluation including:
        1. Diagnosis AND
        2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
    ii. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
    iii. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
    iv. ONE of the following:
        1. Patient's medication history includes use of an immediate-acting opioid OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to immediate-acting opioid AND
    v. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Opioids ER PA - Oxycodone**

Drug Name(s):
OXYCODONE ER
OXYCONTIN
XTAMPZA ER

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.
Criteria for approval require ONE of the following:
A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
B. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
    i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    ii. Prescriber states the patient is currently using the requested agent within the past 180 days OR
C. Patient is undergoing treatment of chronic non-cancer pain AND ALL of the following:
    i. Prescriber provides documentation of a formal, consultative evaluation including:
        1. Diagnosis AND
        2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
    ii. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
    iii. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
    iv. ONE of the following:
        1. Patient's medication history includes use of an immediate-acting opioid OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to immediate-acting opioid AND
    v. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Opioids ER PA - Oxymorphone**

Drug Name(s):
OXYMORPHONE ER

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.
Criteria for approval require ONE of the following:
A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
B. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
- i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
- ii. Prescriber states the patient is currently using the requested agent within the past 180 days OR

C. Patient is undergoing treatment of chronic non-cancer pain AND ALL of the following:
- i. Prescriber provides documentation of a formal, consultative evaluation including:
  - 1. Diagnosis AND
  - 2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
- ii. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
- iii. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
- iv. ONE of the following:
  - 1. Patient's medication history includes use of an immediate-acting opioid OR
  - 2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to immediate-acting opioid AND
- v. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Opioids ER PA - Tapentadol**

Drug Name(s):
NUCYNTA ER

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Program applies to new starts only.
Criteria for approval require ONE of the following:
A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
B. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
    i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    ii. Prescriber states the patient is currently using the requested agent within the past 180 days OR
C. Patient is undergoing treatment of chronic non-cancer pain AND ALL of the following:
    i. Prescriber provides documentation of a formal, consultative evaluation including:
        1. Diagnosis AND
        2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
    ii. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
    iii. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
    iv. ONE of the following:
        1. Patient's medication history includes use of an immediate-acting opioid OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to immediate-acting opioid AND
    v. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Opioids ER PA - Tramadol**

Drug Name(s):

CONZIP
TRAMADOL ER capsule
tramadol ER tablet

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:

Program applies to new starts only.
Criteria for approval require ONE of the following:
A. Patient has a diagnosis of chronic cancer pain due to an active malignancy OR
B. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
    i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    ii. Prescriber states the patient is currently using the requested agent within the past 180 days OR
C. Patient is undergoing treatment of chronic non-cancer pain AND ALL of the following:
    i. Prescriber provides documentation of a formal, consultative evaluation including:
        1. Diagnosis AND
        2. A complete medical history which includes previous and current pharmacological and non-pharmacological therapy AND
    ii. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
    iii. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
    iv. ONE of the following:
        1. Patient's medication history includes use of an immediate-acting opioid OR
        2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to immediate-acting opioid AND
    v. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Oral Immunotherapy Agents PA - Grastek**

Drug Name(s):
GRASTEK

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of allergic rhinitis, with or without conjunctivitis AND
2. Patient's diagnosis is confirmed with ONE of the following:
    A. Positive skin test to ONE of the pollen extracts included in the requested agent: Timothy grass or cross-reactive grass OR
    B. IgE specific antibodies to ONE of the extracts included in the requested agent: Timothy grass or cross-reactive grass AND
3. ONE of the following:
    A. Patient has tried and failed at least TWO standard allergy medications, one of which was an intranasal corticosteroid OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to at least TWO standard allergy medications, one of which was an intranasal corticosteroid AND
4. ONE of the following:
    A. Patient is NOT currently being treated with a subcutaneous injectable immunotherapy OR
    B. Patient will discontinue subcutaneous injectable immunotherapy prior to starting the requested agent AND
5. ONE of the following:
    A. Patient is NOT currently being treated with a beta blocker OR
    B. Patient will discontinue the beta blocker prior to starting the requested agent AND
6. The requested agent will be started, or has already been started, 3 to 4 months before the expected onset of the applicable pollen season AND
7. The first dose is given in the clinic/hospital under direct supervision from the provider for a period of at least 30 minutes AND
8. Patient has been prescribed epinephrine auto-injector for at home emergency use

Age Restrictions:
Patient is between the ages of 5 and 65 years

Prescriber Restrictions:
Prescriber is a specialist (e.g. allergist, immunologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Standard allergy medications:
Oral antihistamines, oral corticosteroids, intranasal corticosteroids, intranasal antihistamines, or leukotriene inhibitors

Prior Authorization Group – **Oral Immunotherapy Agents PA - Oralair**

Drug Name(s):
ORALAIR

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of allergic rhinitis, with or without conjunctivitis AND
2. Patient's diagnosis is confirmed with ONE of the following:
    A. Positive skin test to ONE of the pollen extracts included in the requested agent: Sweet vernal, orchard, perennial rye, Timothy, or Kentucky blue grass OR
    B. IgE specific antibodies to ONE of the extracts included in the requested agent: Sweet vernal, orchard, perennial rye, Timothy, or Kentucky blue grass AND
3. ONE of the following:
    A. Patient has tried and failed at least TWO standard allergy medications, one of which was an intranasal corticosteroid OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to at least TWO standard allergy medications, one of which was an intranasal corticosteroid AND
4. ONE of the following:
    A. Patient is NOT currently being treated with a subcutaneous injectable immunotherapy OR
    B. Patient will discontinue subcutaneous injectable immunotherapy prior to starting the requested agent AND
5. ONE of the following:
    A. Patient is NOT currently being treated with a beta blocker OR
    B. Patient will discontinue the beta blocker prior to starting the requested agent AND
6. The requested agent will be started, or has already been started, 3 to 4 months before the expected onset of the applicable pollen season AND
7. The first dose is given in the clinic/hospital under direct supervision from the provider for a period of at least 30 minutes AND
8. Patient has been prescribed epinephrine auto-injector for at home emergency use

Age Restrictions:
Patient is between the ages of 10 and 65 years

Prescriber Restrictions:
Prescriber is a specialist (e.g. allergist, immunologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Standard allergy medications:
Oral antihistamines, oral corticosteroids, intranasal corticosteroids, intranasal antihistamines, or leukotriene inhibitors

Prior Authorization Group – **Oral Immunotherapy Agents PA - Ragwitek**

Drug Name(s):
RAGWITEK

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of allergic rhinitis, with or without conjunctivitis AND
2. Patient's diagnosis is confirmed with ONE of the following:
    A. Positive skin test to ONE of the pollen extracts included in the requested agent: Short Ragweed OR
    B. IgE specific antibodies to ONE of the extracts included in the requested agent: Short Ragweed AND
3. ONE of the following:
    A. Patient has tried and failed at least TWO standard allergy medications, one of which was an intranasal corticosteroid OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to at least TWO standard allergy medications, one of which was an intranasal corticosteroid AND
4. ONE of the following:
    A. Patient is NOT currently being treated with a subcutaneous injectable immunotherapy OR
    B. Patient will discontinue subcutaneous injectable immunotherapy prior to starting the requested agent AND
5. ONE of the following:
    A. Patient is NOT currently being treated with a beta blocker OR
    B. Patient will discontinue the beta blocker prior to starting the requested agent AND
6. The requested agent will be started, or has already been started, 3 to 4 months before the expected onset of the applicable pollen season AND
7. The first dose is given in the clinic/hospital under direct supervision from the provider for a period of at least 30 minutes AND
8. Patient has been prescribed epinephrine auto-injector for at home emergency use

Age Restrictions:
Patient is between the ages of 18 and 65 years

Prescriber Restrictions:
Prescriber is a specialist (e.g. allergist, immunologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Standard allergy medications:
Oral antihistamines, oral corticosteroids, intranasal corticosteroids, intranasal antihistamines, or leukotriene inhibitors

Prior Authorization Group – **Orkambi PA**

Drug Name(s):
ORKAMBI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. Patient has the presence of the F508del mutation on both alleles (homozygous) of the CFTR gene confirmed by genetic testing AND
3. Patient has had pre-therapeutic/baseline FEV1 levels measured AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another CFTR agent [e.g. Kalydeco (ivacaftor), Symdeko (tezacaftor/ivacaftor and ivacaftor)] OR
    B. Patient is currently being treated with another CFTR agent AND will discontinue the other CFTR agent prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of cystic fibrosis AND
3. Patient has shown improvement or stabilization in FEV1 from pretreatment levels with the requested agent AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another CFTR agent [e.g. Kalydeco (ivacaftor), Symdeko (tezacaftor/ivacaftor and ivacaftor)] OR
    B. Patient is currently being treated with another CFTR agent AND will discontinue the other CFTR agent prior to starting the requested agent

Age Restrictions:
Patient is 2 years of age or over

Prescriber Restrictions:
Prescriber is a specialist (e.g. cystic fibrosis, pulmonologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Orilissa PA**

Drug Name(s):
ORILISSA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of moderate to severe pain associated with endometriosis AND
2. ONE of the following:
    a. Patient has coexisting dyspareunia AND has not received 6 or more months of therapy with the requested agent OR
    b. Patient has coexisting moderate hepatic impairment (Child-Pugh Class B) AND has not received 6 or more months of therapy with the requested agent OR
    c. Patient does not have coexisting dyspareunia or moderate hepatic impairment (Child-Pugh Class B), AND has not received 24 or more months of therapy with the requested agent AND
3. The dose requested is within the FDA approved dosing for the labeled coexisting condition

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
For no prior Orilissa use and for prior Orilissa use, see Other Criteria for approval

Other Criteria:
No prior Orilissa use: Approve 6 months for coexisting dyspareunia OR moderate hepatic impairment, Approve 24 months for no coexisting condition

Prior Orilissa use: Approve remainder of 6 months for coexisting dyspareunia OR moderate hepatic impairment, Approve remainder of 24 months for no coexisting condition

Prior Authorization Group – **Otezla PA**

Drug Name(s):
OTEZLA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ONE of the following:
1. BOTH of the following:
    A. Patient has ONE of the following diagnoses:
        i. Moderate-to-severe plaque psoriasis OR
        ii. Active psoriatic arthritis AND
    B. ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently using the requested agent AND is at risk if therapy is changed OR
        iii. Patient's medication history indicates use of a biologic immunomodulator agent for the same FDA labeled indication OR
        iv. Patient's medication history indicates use of ONE conventional agent prerequisite for the requested indication OR
        v. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to at least ONE conventional prerequisite agent for the requested indication OR
2. Patient has a diagnosis of oral ulcers associated with Behcet's disease (BD)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of moderate-to-severe plaque psoriasis, active psoriatic arthritis, or oral ulcers associated with Behcet's disease (BD) AND
3. Patient has shown clinical improvement (i.e. slowing of disease progression or decrease in symptom severity and/or frequency)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Formulary conventional agent required for diagnoses of moderate-to-severe plaque psoriasis or active psoriatic arthritis

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

Formulary conventional topical or systemic agents for plaque psoriasis include topical corticosteroids, tazarotene, cyclosporine, calcipotriene, methotrexate, tacrolimus, pimecrolimus, or acitretin

NO prerequisites are required for a diagnosis of oral ulcers associated with Behcet's disease (BD)

Prior Authorization Group – **Oxervate PA**

Drug Name(s):
OXERVATE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of neurotrophic keratitis (NK) AND
2. The dose requested is within the FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g., ophthalmologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 8 weeks

Other Criteria:

Prior Authorization Group – **Palynziq PA**

Drug Name(s):
PALYNZIQ

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of phenylketonuria (PKU) AND
2. Patient has a baseline blood Phe level greater than 600 micromol/L (10 mg/dL) AND
3. ONE of the following:
    a. Patient is not also receiving Kuvan OR
    b. Patient has been receiving Kuvan, AND will discontinue at least 14 days prior to receiving Palynziq AND
4. The dose is within the FDA labeled dose for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's prior authorization criteria AND
2. Patient has a diagnosis of phenylketonuria (PKU) AND
3. ONE of the following:
    a. Patient's blood Phe levels are being maintained within the acceptable range OR
    b. Patient has had a decrease in blood Phe level from baseline AND
4. ONE of the following:
    a. Patient is not also receiving Kuvan OR
    b. Patient has been receiving Kuvan, AND will discontinue at least 14 days prior to receiving Palynziq AND
5. The dose is within the FDA labeled dose for the requested indication

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist with knowledge and expertise in metabolic diseases or genetic diseases or has consulted with a specialist in metabolic or genetic diseases

Coverage Duration:
Initial approval 9 months. 12 months for renewal.

Other Criteria:

Prior Authorization Group – **Panzyga PA**

Drug Name(s):
PANZYGA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has ONE of the following diagnoses:
    A. Primary immunodeficiency [including congenital agammaglobulinemia, common variable immunodeficiency (CVID), severe combined immunodeficiency, Wiskott-Aldrich Syndrome, X-linked agammaglobulinemia (XLA), humoral immunodeficiency, IgG subclass deficiency with or without IgA deficiency] OR
    B. Chronic lymphocytic leukemia OR multiple myeloma with reduced IgG AND ONE of the following:
        i. Patient has a history of infections OR
        ii. Patient has evidence of specific antibody deficiency OR
    C. Idiopathic thrombocytopenia purpura AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g. corticosteroids (e.g. methylprednisolone), or immunosuppressants (e.g. azathioprine)] OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    D. Dermatomyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g. corticosteroids (e.g. methylprednisolone) or immunosuppressants (e.g. azathioprine)] OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    E. Polymyositis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g. corticosteroids (e.g. methylprednisolone) or immunosuppressants (e.g. azathioprine)] OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR
    F. Severe rheumatoid arthritis AND ONE of the following:
        i. Patient has failed ONE conventional therapy [e.g. tumor necrosis factor antagonists (e.g. Humira), DMARDS (e.g. methotrexate), Renflexis] OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

Criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 3 months for indications in NHS guidelines, 12 months all others

Other Criteria:
G. Myasthenia gravis (MG) AND ONE of the following:
i. Patient is in acute myasthenic crisis with decompensation (e.g. acute episode of respiratory muscle weakness, respiratory failure, dysphagia, major functional disability responsible for the discontinuation of physical activity) OR
ii. Patient has severe refractory MG (e.g. major functional disability/weakness) AND ONE of the following:
a) Patient has failed ONE immunomodulator therapy (i.e. corticosteroid, pyridostigmine, or azathioprine) OR
b) Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE immunomodulator therapy OR

H. Multiple sclerosis (MS) AND BOTH of the following:
i. Patient has a diagnosis of relapsing remitting MS (RRMS) AND
ii. Patient has had an insufficient response, documented failure, or FDA labeled contraindication(s) to TWO MS agents [e.g. Aubagio, Avonex, Betaseron, glatiramer (i.e. Copaxone, Glatopa), Plegridy, Tecfidera or Tysabri] OR

I. Acquired von Willebrand hemophilia AND ONE of the following:
i. Patient has failed ONE conventional therapy (e.g. desmopressin solution, von Willebrand factor replacement therapy, corticosteroids, cyclophosphamide, FEIBA, Rituxan, or recombinant factor VIIa) OR
ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional therapy OR

J. Refractory pemphigus vulgaris AND ONE of the following:
i. Patient has failed ONE conventional immunosuppressive therapy (e.g. azathioprine, cyclophosphamide, mycophenolate, corticosteroids) OR
ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE conventional immunosuppressive therapy OR

2. ONE of the following:

A. Patient has another FDA labeled indication for the requested agent OR
B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Indications with 3 month approval duration:
Idiopathic thrombocytopenia purpura, Acquired von Willebrand hemophilia, Guillain-Barre Syndrome, Lambert-Eaton myasthenia syndrome, Myasthenia gravis, Kawasaki disease, CMV induced pneumonitis in solid organ transplant, Toxic shock syndrome due to invasive group A streptococcal, Toxic epidermal necrolysis and Steven Johnsons syndrome

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

Prior Authorization Group – **Pegylated Interferon PA**

Drug Name(s):
PEGASYS
PEGASYS PROCLICK

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ONE of the following:
A. Patient has a diagnosis of chronic hepatitis B AND BOTH of the following:
i. The chronic hepatitis B infection has been confirmed by serological markers AND
ii. Patient has NOT been administered the requested agent for more than 48 weeks for the treatment of chronic hepatitis B OR
B. BOTH of the following:
i. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND
ii. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype OR
C. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
12 months for all other diagnoses. For hep B, hep C see Other Criteria

Other Criteria:
No prior peginterferon alfa use, approve 48 weeks for hepatitis B virus infection. Prior peginterferon alfa use, approve remainder of 48 weeks of total therapy for hepatitis B virus infection

Duration of therapy for hep C: Based on FDA approved labeling or AASLD/IDSA guideline supported

Prior Authorization Group – **Praluent PA**

Drug Name(s):
PRALUENT

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA approved diagnosis for the requested agent AND
2. ONE of the following:
    A. If the diagnosis is heterozygous familial hypercholesterolemia (HeFH), ONE of the following:
        i. Genetic confirmation of one mutant allele at the LDLR, Apo-B, PCSK9, or ARH adaptor protein 1/LDLRAP1 gene locus OR
        ii. BOTH of the following:
            1. Total cholesterol greater than 290 mg/dL (greater than 7.5 mmol/L) (pretreatment or highest level while on treatment) OR LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) (pretreatment or highest level while on treatment) AND
            2. History of tendon xanthomas in ONE of the following:
                a. Patient
                b. Patient's first degree relative (i.e. parent, sibling, or child)
                c. Patient's second degree relative (e.g. grandparent, uncle, or aunt) OR
        iii. Patient has a Dutch Lipid Clinic Network Criteria score of greater than 8 OR
    B. Patient's indication is to reduce the risk of myocardial infarction, stroke, and unstable angina in patients with established cardiovascular disease (angina pectoris, coronary heart disease, myocardial infarction, transient ischemic attacks, cerebrovascular disease (CeVD) or peripheral vascular disease (PVD) or after coronary revascularization or carotid endarterectomy) OR
    C. Patient has a diagnosis of primary hyperlipidemia (not associated with HeFH or established cardiovascular disease) AND

Initial criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist (e.g. cardiologist or endocrinologist) or the prescriber has consulted with a specialist

Coverage Duration:

Approval will be for 12 months

Other Criteria:

3. ONE of the following:
    A. ONE of the following:
        1. Patient is currently (for the past 90 days) on high-intensity statin therapy (i.e. rosuvastatin 20-40 mg or atorvastatin 40-80 mg) OR
        2. BOTH of the following:
            a. Patient has tried and is intolerant to high-intensity statin therapy AND
            b. Patient is currently (for the past 90 days) on low or moderate intensity statin therapy OR
    B. Patient has documented intolerance* to TWO different statins (*intolerance is defined as inability to tolerate the lowest FDA approved starting dose of a statin) OR
    C. Patient has an FDA labeled contraindication to a statin AND
4. Praluent (alirocumab) and Repatha (evolocumab) will not be used concurrently with each other

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA approved diagnosis for the requested agent AND
3. Patient has shown clinical benefit with the requested agent AND
4. ONE of the following:
    A. ONE of the following:
        1. Patient is currently (for the past 90 days) on high-intensity statin therapy (i.e. rosuvastatin 20-40 mg or atorvastatin 40-80 mg) OR
        2. BOTH of the following:
            a. Patient has tried and is intolerant to high-intensity statin therapy AND
            b. Patient is currently (for the past 90 days) on low or moderate intensity statin therapy OR
    B. Patient has documented intolerance* to TWO different statins (*intolerance is defined as inability to tolerate the lowest FDA approved starting dose of a statin) OR

C. Patient has an FDA labeled contraindication to a statin AND

5. Praluent (alirocumab) and Repatha (evolocumab) will not be used concurrently with each other

Prior Authorization Group – **Prolia PA**

Drug Name(s):
PROLIA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. ONE of the following:
    A. Patient is a male or a postmenopausal female with a diagnosis of osteoporosis defined as ONE of the following:
        i. Patient has a history of vertebral fracture(s), or low trauma or fragility fracture(s) [e.g. prior fracture from minor trauma such as falling from standing height or less] within the past 5 years OR
        ii. Patient has a T-score that is -2.5 or lower AND ONE of the following:
            1. Patient is female and medication history includes use of either a bisphosphonate or selective estrogen receptor (SERM) OR
            2. Patient is male and medication history includes use of a bisphosphonate OR
            3. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate or SERM (bisphosphonate or SERM for female patients, bisphosphonate for male patients) OR
    B. Patient is requesting the agent for osteopenia (osteoporosis prophylaxis) AND ALL of the following:
        i. ONE of the following:
            1. Patient is a male 50 years of age and over OR
            2. Patient is a postmenopausal female AND
        ii. Patient has a T-score between -1.0 to -2.50 AND
        iii. ONE of the following:
            1. 10-year probability of a hip fracture 3% and greater per FRAX OR
            2. 10-year probability of a major OP-related fracture 20% and greater per FRAX AND
        iv. ONE of the following:
            1. Patient is female and medication history includes use of a bisphosphonate or SERM OR

2. Patient is male and medication history includes use of a bisphosphonate OR
3. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate or SERM (bisphosphonate or SERM for female patients, bisphosphonate for male patients) OR

Criteria continues: See Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

C. Patient is a female with a diagnosis of breast cancer who is receiving aromatase inhibitor therapy AND ONE of:
- i. Patient has a history of vertebral fracture(s), or low trauma or fragility fracture(s) [e.g. prior fracture from minor trauma such as falling from standing height or less] within the past 5 years OR
- ii. Patient has a T-score at or below -1 AND ONE of:
  1. Patient's medication history includes use of a bisphosphonate OR
  2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate OR

D. Patient is a male with a diagnosis of prostate cancer receiving androgen deprivation therapy (ADT) AND ONE of:
- i. Patient has a history of vertebral fracture(s), or low trauma or fragility fracture(s) [e.g. prior fracture from minor trauma such as falling from standing height or less] within the past 5 years OR
- ii. BOTH of:
  1. ONE of:
     a. Patient has a T-score at or below -1 OR
     b. Patient has a history of an osteoporotic fracture AND
  2. ONE of:
     a. Patient's medication history includes use of a bisphosphonate OR
     b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate OR

E. Patient has a diagnosis of glucocorticoid-induced osteoporosis AND ALL of:
- i. Patient is either initiating or continuing systemic glucocorticoids in a daily dose equivalent to 7.5 mg or greater of prednisone AND

ii. Patient is expected to remain on glucocorticoids for at least 6 months AND
iii. ONE of:
1. Patient has a history of vertebral fracture(s), or low trauma or fragility fracture(s) [e.g. prior fracture from minor trauma such as falling from standing height or less] within the past 5 years OR
2. Patient has a T-score that is -2.5 or lower AND ONE of:
a. Patient is female and medication history includes use of either a bisphosphonate or selective estrogen receptor (SERM) OR
b. Patient is male and medication history includes use of a bisphosphonate OR
c. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate or SERM (bisphosphonate or SERM for female patients, bisphosphonate for male patients) AND

2. ONE of:
A. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR
B. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR
C. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) AND
3. ONE of:
A. Patient is not receiving concomitant Forteo (teriparatide), Xgeva (denosumab), bisphosphonate, or SERM therapy within the past 90 days OR
B. Patient will discontinue the current Forteo (teriparatide), Xgeva (denosumab), bisphosphonate, or SERM therapy prior to initiating therapy with the requested agent AND
4. Dose requested is within the FDA approved labeling

Prior Authorization Group – **Promacta PA**

Drug Name(s):
PROMACTA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ONE of the following:
1. Patient (pt) has a diagnosis of chronic idiopathic thrombocytopenic purpura (ITP) AND ONE of the following:
    A. Pt has had an insufficient response to single treatment with corticosteroids or immunoglobulins (IVIg or anti-D) OR
    B. Pt has had an insufficient response to a splenectomy OR
    C. BOTH of the following:
        i. Pt is NOT a candidate for splenectomy AND
        ii. Pt has a documented intolerance, FDA labeled contraindication or hypersensitivity to corticosteroids or immunoglobulins (IVIg or anti-D) OR
2. Pt has a diagnosis of hepatitis C associated thrombocytopenia AND ONE of the following:
    A. Pt's platelet count is less than 75 x 109/L AND the intent is to increase platelet counts sufficiently to initiate interferon therapy OR
    B. Pt is on concurrent therapy with a pegylated interferon and ribavirin AND is at risk for discontinuing HCV therapy due to thrombocytopenia OR
3. Pt has a diagnosis of severe aplastic anemia (SAA) AND ALL of the following:
    A. At least 2 of the following blood criteria:
        i. Neutrophils less than 0.5 X 109/L OR
        ii. Platelets less than 20 X 109/L OR
        iii. Reticulocytes less than 1% corrected (percentage of actual hematocrit [Hct] to normal Hct) or reticulocyte count less than 20 X 109/L AND
    B. At least 1 of the following marrow criteria:
        i. Severe hypocellularity is less than 25% OR
        ii. Moderate hypocellularity is 25-50% with hematopoietic cells representing less than 30% of residual cells AND
    C. ONE of the following:
        i. Pt will be using the requested agent in combination with standard immunosuppressive therapy (i.e., antithymocyte globulin (ATG) and cyclosporine) for the first-line treatment of SAA (FSAA) OR
        ii. ONE of following:

1. Pt has refractory (RSAA) defined as an insufficient response to immunosuppressive therapy [i.e., failure to ATG and cyclosporine] OR
2. Pt has a documented intolerance, FDA labeled contraindication, or hypersensitivity to horse ATG and cyclosporine

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial 6 months ITP & FSAA, 48 weeks HCV, 16 weeks RSAA Renewal 12 months ITP & SAA, 48 weeks HCV

Other Criteria:

Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of chronic idiopathic thrombocytopenic purpura (ITP) AND ONE of the following:
        i. Patient's platelet count is 50 x 109/L or greater OR
        ii. Patient's platelet count has increased sufficiently to avoid clinically important bleeding OR
    B. Patient has a diagnosis of hepatitis C associated thrombocytopenia AND BOTH of the following:
        i. ONE of the following:
            1. Patient will be initiating hepatitis C therapy with interferon and ribavirin OR
            2. Patient will be maintaining hepatitis C therapy with interferon and ribavirin at the same time as the requested agent AND
        ii. ONE of the following:
            1. Patient's platelet count is 90 x 109/L or greater OR
            2. Patient's platelet count has increased sufficiently to initiate or maintain interferon based therapy for the treatment of hepatitis C OR
    C. Patient has a diagnosis of refractory severe aplastic anemia (SAA) AND has had a hematological response by week 16 defined as ONE of the following:
        i. Platelet count increases to 20 x 109/L above baseline OR
        ii. Stable platelet counts with transfusion independence for a minimum of 8 weeks OR
        iii. Hemoglobin increase by greater than 1.5 g/dL OR

iv. Reduction in 4 units or greater of red blood cell (RBC) transfusions for 8 consecutive weeks OR

v. An absolute neutrophil count (ANC) increase of 100% OR

vi. An absolute neutrophil count (ANC) increase greater than 0.5 x 109/L OR

D. Patient has a diagnosis of severe aplastic anemia AND BOTH of the following:

i. Patient is using the requested agent in combination with standard immunosuppressive therapy (i.e., antithymocyte globulin (ATG) and cyclosporine) for the first-line treatment of severe aplastic anemia AND

ii. ONE of the following:

1. Patient has had a complete response by 6 months defined as hematological parameters meeting ALL of the following values:

a) An absolute neutrophil count (ANC) greater than 1,000/mcL AND

b) Platelet count greater than 100 x 109/L AND

c) Hemoglobin greater than 10 g/dL OR

2. Patient has had a partial response by 6 months defined as meeting TWO of the following values:

a) An absolute neutrophil count (ANC) greater than 500/mcL OR

b) Platelet count greater than 20 x 109/L OR

c) Reticulocyte count greater than 60,000/mcL

Prior Authorization Group – **Pulmonary Hypertension PA - Adcirca**

Drug Name(s):
ADCIRCA
tadalafil 20 mg tablet (generic for Adcirca)

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent AND Concurrently taking an phosphodiesterase type 5 (PDE-5) inhibitor (e.g. Cialis, Viagra) with the requested agent

Required Medical:
Criteria for initial approval require ONE of the following:
A. BOTH of the following:
- i. ONE of the following:
  - a. There is evidence of a claim that the patient (pt) is currently being treated with the requested agent within the past 90 days OR
  - b. Prescriber states pt is using the requested agent AND is at risk if therapy is changed AND
- ii. Pt has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR

B. Pt has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following:
- i. Pt's World Health Organization (WHO) functional class is II or greater AND
- ii. Pt has a mean pulmonary arterial pressure greater than or equal to 25 mmHg AND
- iii. Pt has a pulmonary vascular resistance greater than 3 Wood units AND
- iv. ONE of the following:
  - a. Requested agent will be utilized as monotherapy OR
  - b. Requested agent is for use in combination with ambrisentan for dual therapy ONLY OR
  - c. Requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy: except for dual therapy requests for tadalafil with ambrisentan), then BOTH of the following:
    1. Pt has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
    2. Requested agent is in a different therapeutic class OR

d. Requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND ALL of the following:

1. A prostanoid has been started as one of the agents in the triple therapy unless the pt has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a prostanoid AND
2. Pt has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
3. All three agents in the triple therapy are from a different therapeutic class OR

C. Pt has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Criteria for renewal approval require ALL of the following:

1. Pt has been previously approved for the requested agent through the plan's PA criteria AND
2. Pt has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. Pt is responding to therapy with the requested agent

Prior Authorization Group – **Pulmonary Hypertension PA - Adempas**

Drug Name(s):
ADEMPAS

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require BOTH of the following:
1. ONE of:
    A. BOTH of:
        i. ONE of:
            a. There is evidence of a claim that patient (pt) is currently being treated with the requested agent within the past 90 days OR
            b. Prescriber states the pt is using the requested agent AND is at risk if therapy is changed AND
        ii. Pt has an FDA labeled indication for the requested agent OR
    B. Pt has a diagnosis (dx) of CTEPH, WHO Group 4 as determined by ventilation-perfusion scan and a confirmatory selective pulmonary angiography AND ALL of:
        i. ONE of:
            a. Pt is NOT a candidate for surgery OR
            b. Pt has had pulmonary endarterectomy AND has persistent or recurrent disease AND
        ii. Pt has a mean pulmonary arterial pressure greater than or equal to 25 mmHg AND
        iii. Pt has a pulmonary capillary wedge pressure less than or equal to 15 mmHg OR
    C. Pt has a dx of PAH, WHO Group 1 as determined by right heart catheterization AND ALL of:
        i. Pt's WHO functional class is II or greater AND
        ii. Pt has a mean pulmonary arterial pressure greater than or equal to 25 mmHg AND
        iii. Pt has a pulmonary vascular resistance greater than 3 Wood units AND
2. ONE of:
    A. Requested agent will be utilized as monotherapy OR
    B. Requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), then BOTH of:

i. Pt has unacceptable or deteriorating clinical status despite established pharmacotherapy AND
ii. Requested agent is in a different therapeutic class OR

C. Requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), then ALL of:
i. Prostanoid therapy has been started as one of the agents in the triple therapy unless the pt has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a prostanoid AND
ii. Pt has unacceptable or deteriorating clinical status despite established pharmacotherapy AND
iii. All three agents in the triple therapy are from a different therapeutic class

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Pt has been previously approved for the requested agent through the plan's PA criteria AND
2. Pt has an FDA labeled indication for the requested agent AND
3. Pt is responding to therapy with the requested agent

Prior Authorization Group – **Pulmonary Hypertension PA - Bosentan**

Drug Name(s):
bosentan tablet
TRACLEER

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
Elevated liver enzymes accompanied by signs or symptoms of liver dysfunction/injury or a bilirubin level of 2 times the ULN (upper limit of normal) or greater AND FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ONE of the following:
1. BOTH of the following:
    A. ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is using the requested agent AND is at risk if therapy is changed AND
    B. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
2. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1, as determined by right heart catheterization, AND ALL of the following:
    i. Patient's WHO functional class is II or greater AND
    ii. Patient has a mean pulmonary arterial pressure greater than or equal to 25 mmHg AND
    iii. Patient has a pulmonary vascular resistance greater than 3 Wood units AND
    iv. ONE of the following:
        a. Requested agent will be utilized as monotherapy OR
        b. Requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), then BOTH of the following:
            1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
            2. Requested agent is in a different therapeutic class OR
        c. Requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), then ALL of the following:

1. A prostanoid has been started as one of the agents in the triple therapy unless the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a prostanoid AND
2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
3. All three agents in the triple therapy are from a different therapeutic class OR

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. Patient is responding to therapy with the requested agent

Prior Authorization Group – **Pulmonary Hypertension PA - Letairis**

Drug Name(s):
ambrisentan tablet
LETAIRIS

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
b. Prescriber states the patient is using the requested agent AND is at risk if therapy is changed AND
ii. Patient has an FDA labeled indication for the requested agent OR
B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following:
i. Patient's WHO functional class is II or greater AND
ii. Patient has a mean pulmonary arterial pressure greater than or equal to 25 mmHg AND
iii. Patient has a pulmonary vascular resistance greater than 3 Wood units AND
iv. ONE of the following:
a. Requested agent will be utilized as monotherapy OR
b. Requested agent is for use in combination with tadalafil for dual therapy ONLY OR
c. Requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy: except dual therapy requests for ambrisentan with tadalafil), then BOTH of the following:
1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
2. Requested agent is in a different therapeutic class OR
d. Requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), then ALL of the following:
1. A prostanoid has been started as one of the agents in the triple therapy unless the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a prostanoid AND

2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
3. All three agents in the triple therapy are from a different therapeutic class

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient is responding to therapy with the requested agent

Prior Authorization Group – **Pulmonary Hypertension PA - Opsumit**

Drug Name(s):
OPSUMIT

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
b. Prescriber states the patient is using the requested agent AND is at risk if therapy is changed AND
ii. Patient has an FDA labeled indication for the requested agent OR
B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following:
i. Patient's WHO functional class is II or greater AND
ii. Patient has a mean pulmonary arterial pressure greater than or equal to 25 mmHg AND
iii. Patient has a pulmonary vascular resistance greater than 3 Wood units AND
iv. ONE of the following:
a. Requested agent will be utilized as monotherapy OR
b. Requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), then BOTH of the following:
1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
2. Requested agent is in a different therapeutic class OR
c. Requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), then ALL of the following:
1. A prostanoid has been started as one of the agents in the triple therapy unless the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a prostanoid AND
2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
3. All three agents in the triple therapy are from a different therapeutic class

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient is responding to therapy with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Pulmonary Hypertension PA - Orenitram**

Drug Name(s):
ORENITRAM

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
b. Prescriber states the patient is using the requested agent AND is at risk if therapy is changed AND
ii. Patient has an FDA labeled indication for the requested agent OR
B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following
i. Patient's World Health Organization (WHO) functional class is II or greater AND
ii. Patient has a mean pulmonary arterial pressure greater than or equal to 25 mmHg AND
iii. Patient has a pulmonary vascular resistance greater than 3 Wood units AND
iv. ONE of the following:
a. Requested agent will be utilized as monotherapy OR
b. Requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), then BOTH of the following:
1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
2. Requested agent is in a different therapeutic class OR
c. Requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), then ALL of the following:
1. Patient is WHO functional class III or IV AND
2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
3. All three agents in the triple therapy are from a different therapeutic class

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient is responding to therapy with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Pulmonary Hypertension PA - Sildenafil**

Drug Name(s):
REVATIO
sildenafil injection, suspension, 20 mg tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent AND Concurrently taking an phosphodiesterase type 5 (PDE-5) inhibitor (e.g. Cialis, Viagra) with the requested agent

Required Medical:
Criteria for initial approval require ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
b. Prescriber states the patient is using the requested agent AND is at risk if therapy is changed AND
ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following:
i. Patient's World Health Organization (WHO) functional class is II or greater AND
ii. Patient has a mean pulmonary arterial pressure greater than or equal to 25 mmHg AND
iii. Patient has a pulmonary vascular resistance greater than 3 Wood units AND
iv. ONE of the following:
a. Requested agent will be utilized as monotherapy OR
b. Requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), then BOTH of the following:
1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
2. Requested agent is in a different therapeutic class OR
c. Requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND ALL of the following:

1. A prostanoid has been started as one of the agents in the triple therapy unless the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a prostanoid AND
2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
3. All three agents in the triple therapy are from a different therapeutic class OR

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. Patient is responding to therapy with the requested agent

Prior Authorization Group – **Pulmonary Hypertension PA - Uptravi**

Drug Name(s):
UPTRAVI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
b. Prescriber states the patient is using the requested agent AND is at risk if therapy is changed AND
ii. Patient has an FDA labeled indication for the requested agent OR
B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following
i. Patient's World Health Organization (WHO) functional class is II or greater AND
ii. Patient has a mean pulmonary arterial pressure greater than or equal to 25 mmHg AND
iii. Patient has a pulmonary vascular resistance greater than 3 Wood units AND
iv. ONE of the following:
a. Requested agent will be utilized as monotherapy OR
b. Requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), then BOTH of the following:
1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
2. Requested agent is in a different therapeutic class OR
c. Requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), then BOTH of the following:
1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
2. All three agents in the triple therapy are from a different therapeutic class

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient is responding to therapy with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Pulmonary Hypertension PA - Ventavis**

Drug Name(s):
VENTAVIS

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ONE of the following:
A. BOTH of the following:
i. ONE of the following:
a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
b. Prescriber states the patient is using the requested agent AND is at risk if therapy is changed AND
ii. Patient has an FDA labeled indication for the requested agent OR
B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following
i. Patient's World Health Organization (WHO) functional class is II or greater AND
ii. Patient has a mean pulmonary arterial pressure greater than or equal to 25 mmHg AND
iii. Patient has a pulmonary vascular resistance greater than 3 Wood units AND
iv. ONE of the following:
a. Requested agent will be utilized as monotherapy OR
b. Requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), then BOTH of the following:
1. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
2. Requested agent is in a different therapeutic class OR
c. Requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), then ALL of the following:
1. Patient is WHO functional class III or IV AND
2. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND
3. All three agents in the triple therapy are from a different therapeutic class

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient is responding to therapy with the requested agent

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Qbrexza PA**

Drug Name(s):
QBREXZA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require the following:
1. Patient has a diagnosis of primary axillary hyperhidrosis

Age Restrictions:
Patient is 9 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Quinine PA**

Drug Name(s):
QUALAQUIN
quinine sulfate capsule

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ONE of the following:
1. Patient has one of the following diagnoses:
    a. Uncomplicated malaria OR
    b. Babesiosis OR
    c. An indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
7 days for malaria, 10 days for babesiosis, 12 months for all other indications

Other Criteria:

Prior Authorization Group – **Radicava PA**

Drug Name(s):
RADICAVA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of amyotrophic lateral sclerosis (ALS) [also known as Lou Gehrig's disease] AND
2. ALL of the following:
    a. Patient is able to perform most activities of daily living AND
    b. Patient has had the diagnosis of amyotrophic lateral sclerosis (ALS) for a duration of 2 years or less AND
    c. Patient has a baseline percent predicted forced vital capacity (FVC) of 80% or greater AND
3. The requested dose is within FDA labeled dosing

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of amyotrophic lateral sclerosis (ALS) [also known as Lou Gehrig's disease] AND
3. Patient has shown clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. neurologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal

Other Criteria:

Prior Authorization Group – **Rayos PA**

Drug Name(s):
RAYOS

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    a. Patient has tried and failed generic oral prednisone AND at least 1 other different generic oral corticosteroid agent (e.g. dexamethasone, methylprednisolone) OR
    b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to generic oral prednisone AND at least 1 other different generic oral corticosteroid agent (e.g. dexamethasone, methylprednisolone)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 6 months

Other Criteria:

Prior Authorization Group – **Regranex PA**

Drug Name(s):
REGRANEX

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ONE of the following:
1. BOTH of the following:
    A. Patient has a diagnosis of lower extremity diabetic neuropathic ulcer(s) that extend into the subcutaneous tissue or beyond AND
    B. The ulcer(s) intended for treatment has an adequate blood supply OR
2. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Relistor PA**

Drug Name(s):
RELISTOR

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. ONE of the following diagnoses:
    A. Patient has opioid-induced constipation (OIC) with advanced illness or pain caused by active cancer and is receiving palliative care AND the requested agent is Relistor (methylnaltrexone) injection OR
    B. Patient has opioid-induced constipation (OIC) and chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment AND
2. Patient has chronic use of an opioid agent in the past 90 days AND
3. ONE of the following:
    A. Patient has a medication history that includes lactulose or polyethylene glycol 3350 OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to lactulose or polyethylene glycol 3350

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Repatha PA**

Drug Name(s):
REPATHA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA approved diagnosis for the requested agent AND
2. ONE of the following:
    A. If the diagnosis is heterozygous familial hypercholesterolemia (HeFH), ONE of the following:
        i. Genetic confirmation of one mutant allele at the LDLR, Apo-B, PCSK9, or ARH adaptor protein 1/LDLRAP1 gene locus OR
        ii. BOTH of the following:
            1. Total cholesterol greater than 290 mg/dL (greater than 7.5 mmol/L) (pretreatment or highest level while on treatment) OR LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) (pretreatment or highest level while on treatment) AND
            2. History of tendon xanthomas in ONE of the following:
                a. Patient
                b. Patient's first degree relative (i.e. parent, sibling, or child)
                c. Patient's second degree relative (e.g. grandparent, uncle, or aunt) OR
        iii. Patient has a Dutch Lipid Clinic Network Criteria score of greater than 8 OR
    B. If the diagnosis is homozygous familial hypercholesterolemia (HoFH), ONE of the following:
        i. Genetic confirmation of two mutant alleles at the LDLR, Apo-B, PCSK9, or ARH adaptor protein 1/LDLRAP1 gene locus OR
        ii. Untreated LDL-C greater than 500 mg/dL (greater than 13 mmol/L) or treated LDL-C 300 mg/dL or greater (7.76 mmol/L or greater) with ONE of the following:
            a. Patient had cutaneous or tendon xanthoma before age 10 years OR
            b. Untreated elevated cholesterol levels consistent with heterozygous FH in both parents [untreated LDL-C greater than

190 mg/dL (greater than 4.9 mmol/L) or untreated total cholesterol greater than 290 mg/dL (greater than 7.5 mmol/L)] OR

Initial criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist (e.g. cardiologist or endocrinologist) or the prescriber has consulted with a specialist

Coverage Duration:

Approval will be for 12 months

Other Criteria:

C. Patient's indication is to reduce the risk of myocardial infarction, stroke, and coronary revascularization in patients with established cardiovascular disease (angina pectoris, coronary heart disease, myocardial infarction, transient ischemic attacks, cerebrovascular disease (CeVD) or peripheral vascular disease (PVD) or after coronary revascularization or carotid endarterectomy) OR

D. Patient has a diagnosis of primary hyperlipidemia (not associated with HeFH, HoFH, or established cardiovascular disease) AND

3. ONE of the following:

A. ONE of the following:

1. Patient is currently (for the past 90 days) on high-intensity statin therapy (i.e. rosuvastatin 20-40 mg or atorvastatin 40-80 mg) OR

2. BOTH of the following:

a. Patient has tried and is intolerant to high-intensity statin therapy AND

b. Patient is currently (for the past 90 days) on low or moderate intensity statin therapy OR

B. Patient has documented intolerance* to TWO different statins (*intolerance is defined as inability to tolerate the lowest FDA approved starting dose of a statin) OR

C. Patient has an FDA labeled contraindication to a statin AND

4. Praluent (alirocumab) and Repatha (evolocumab) will not be used concurrently with each other

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has an FDA approved diagnosis for the requested agent AND
3. Patient has shown clinical benefit with the requested agent AND
4. ONE of the following:
    A. ONE of the following:
        1. Patient is currently (for the past 90 days) on high-intensity statin therapy (i.e. rosuvastatin 20-40 mg or atorvastatin 40-80 mg) OR
        2. BOTH of the following:
            a. Patient has tried and is intolerant to high-intensity statin therapy AND
            b. Patient is currently (for the past 90 days) on low or moderate intensity statin therapy OR
    B. Patient has documented intolerance* to TWO different statins (*intolerance is defined as inability to tolerate the lowest FDA approved starting dose of a statin) OR
    C. Patient has an FDA labeled contraindication to a statin AND
5. Praluent (alirocumab) and Repatha (evolocumab) will not be used concurrently with each other

Prior Authorization Group – **Ruzurgi PA**

Drug Name(s):
RUZURGI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require the following:
1. Patient has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) confirmed by at least ONE of the following:
    A. Electrodiagnostic studies (e.g., electromyography) OR
    B. Antibody testing

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) AND
3. Patient has shown clinical benefit with the requested agent

Age Restrictions:
Patient is 6 to less than 17 years of age

Prescriber Restrictions:
Prescriber is a specialist (e.g., neurologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Samsca PA**

Drug Name(s):
SAMSCA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the request agent AND Any underlying liver disease, including cirrhosis

Required Medical:
Criteria for approval require ALL of the following:
1. The requested agent was initiated (or re-initiated) in the hospital AND
2. Prior to initiating the requested agent, patient has or had a diagnosis of clinically significant hypervolemic or euvolemic hyponatremia defined by ONE of the following:
    a. Serum sodium is less than 125 mEq/L OR
    b. Serum sodium is 125 mEq/L or greater AND patient has symptomatic hyponatremia that has resisted correction with fluid restriction AND
3. Medications known to cause hyponatremia have been evaluated and discontinued when appropriate AND
4. Patient has NOT already received 30 days of therapy with the requested agent following the most recent hospitalization for initiation of therapy AND
5. Requested dose is within the FDA approved labeled dosing (Initial dose is 15 mg once daily, may be increased to 30 mg once daily after 24 hours, up to a maximum daily dose of 60 mg, as needed to achieve the desired level of serum sodium. Do not administer the requested agent for more than 30 days to minimize the risk of liver injury)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 30 days

Other Criteria:

Prior Authorization Group – **Self - Administered Oncology PA**

Drug Name(s):
abiraterone 250 mg tablet
AFINITOR
AFINITOR DISPERZ
ALECENSA
ALUNBRIG
BALVERSA
bexarotene capsule
BOSULIF
BRAFTOVI
CABOMETYX
CALQUENCE
CAPRELSA
COMETRIQ
COPIKTRA
COTELLIC
DAURISMO
ERIVEDGE
ERLEADA
erlotinib tablet
FARYDAK
GILOTRIF
GLEEVEC
HEXALEN
IBRANCE
ICLUSIG
IDHIFA
imatinib mesylate tablet
IMBRUVICA
INLYTA
INREBIC
IRESSA
JAKAFI
KISQALI
KISQALI FEMARA CO PACK
LENVIMA
LONSURF
LORBRENA
LYNPARZA
MATULANE
MEKINIST
MEKTOVI
NERLYNX
NEXAVAR
NINLARO

NUBEQA
ODOMZO
PIQRAY
POMALYST
REVLIMID
ROZLYTREK
RUBRACA
RYDAPT
SPRYCEL
STIVARGA
SUTENT
SYLATRON
TAFINLAR
TAGRISSO
TALZENNA
TARCEVA
TARGRETIN
TASIGNA
THALOMID
TIBSOVO
tretinoin capsule
TURALIO
TYKERB
VENCLEXTA
VENCLEXTA STARTING PACK
VERZENIO
VITRAKVI
VIZIMPRO
VOTRIENT
XALKORI
XOSPATA
XPOVIO
XTANDI
YONSA
ZEJULA
ZELBORAF
ZOLINZA
ZYDELIG
ZYKADIA
ZYTIGA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:

This program applies to new starts only.

Criteria for approval require BOTH of the following:

1. ONE of the following:
    - A. Patient has an FDA labeled indication for the requested agent OR
    - B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    - A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    - B. Prescriber states the patient is currently being treated with the requested agent OR
    - C. ALL of the following:
        - i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        - ii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent AND
        - iii. ONE of the following:
            1. Patient has tried and failed the first line agent for the intended indication (if applicable) OR
            2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the first line agent AND
        - iv. Patient does NOT have any FDA labeled limitation(s) of use that is not otherwise supported in NCCN guidelines

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Signifor LAR PA**

Drug Name(s):
SIGNIFOR LAR

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
Severe hepatic impairment (i.e. Child Pugh C)

Required Medical:
Criteria for initial approval require ONE of the following:
1. Patient has a diagnosis of acromegaly AND ONE of the following:
    i. Patient had an inadequate response to surgery defined by ONE of the following:
        a. Growth hormone level greater than 5 ng/mL OR
        b. IGF-1 level greater than 1.9 U/mL for males or greater than 2.2 U/mL for females OR
    ii. Patient is NOT a candidate for surgical resection OR
2. Patient has a diagnosis of Cushing's disease AND ONE of the following:
    i. Patient has recurrence or persistence of symptoms after pituitary surgical resection OR
    ii. Patient is NOT a candidate for pituitary surgical resection OR
3. Patient has an indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of acromegaly AND ONE of the following:
        i. Growth hormone level less than 5 ng/mL OR
        ii. IGF-1 level less than 1.9 U/mL for males or less than 2.2 U/mL for females OR
        iii. Clinical improvement (e.g. reduction in tumor size, decreased headaches, improved cardiovascular or respiratory symptoms) OR
    B. Patient has a diagnosis of Cushing's disease AND BOTH of the following:
        i. Patient has a urinary free cortisol level less than or equal to the upper limit of normal AND
        ii. Patient has shown improvement in at least ONE of the following clinical signs and symptoms
            1. Fasting plasma glucose OR
            2. Hemoglobin A1c OR
            3. Hypertension OR

4. Weight OR

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial: Acromegaly - 6 months, Cushing - 7 months, All other dxs - 12 months, Renewal: 12 months

Other Criteria:

Prior Authorization Group – **Signifor PA**

Drug Name(s):
SIGNIFOR

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
Severe hepatic impairment (i.e. Child Pugh C)

Required Medical:
Criteria for initial approval require ONE of the following:
1. Patient has a diagnosis of Cushing's disease (CD) AND ONE of the following:
    i. Patient has had recurrence or persistence of symptoms after pituitary surgical resection OR
    ii. Patient is NOT a candidate for pituitary surgical resection OR
2. Patient has an indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of Cushing's disease (CD) AND BOTH of the following:
        i. Patient has had a 15% or greater decrease in urinary free cortisol levels AND
        ii. Patient has shown improvement in at least ONE of the following clinical signs and symptoms:
            1. Fasting plasma glucose OR
            2. Hemoglobin A1c OR
            3. Hypertension OR
            4. Weight OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Initial approval: 3 months for CD, 12 months for all other diagnoses, Renewal approval: 12 months

Other Criteria:

Prior Authorization Group – **Sivextro PA**

Drug Name(s):

SIVEXTRO tablet

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:

Criteria for approval require ALL of the following:

1. Patient has ONE of the following:
    a. BOTH of the following:
        i. A documented acute bacterial skin and skin structure infection (ABSSSI) defined as a bacterial infection of the skin with a lesion size area of at least 75 cm2 (lesion size measured by the area of redness, edema, or induration) AND
        ii. The infection is due to Staphylococcus aureus, Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus anginosus, Streptococcus intermedius, Streptococcus constellatus, or Enterococcus faecalis OR
    b. Another indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. The requested agent is prescribed by an infectious disease specialist or the prescriber has consulted with an infectious disease specialist on treatment of this patient OR
    b. The requested agent is NOT prescribed by an infectious disease specialist or the prescriber has NOT consulted with an infectious disease specialist on treatment of this patient AND ONE of the following:
        i. There is documentation of resistance to beta lactams, macrolides, clindamycin, tetracycline, and co-trimoxazole at the site of infection OR the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to beta lactams, macrolides, clindamycin, tetracyclines, and co-trimoxazole OR
        ii. There is documentation of resistance to vancomycin at the site of infection OR the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to vancomycin AND
3. ONE of the following:
    a. Patient is NOT currently being treated for the same infection with linezolid OR
    b. The current treatment with linezolid for the same infection will be discontinued before starting therapy with the requested agent AND
4. The requested dose is within the FDA and/or compendia labeled dosage

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be 6 days for ABSSSI or 30 days for all other indications

Other Criteria:

Prior Authorization Group – **Somatostatin Analogs PA - Octreotide**

Drug Name(s):
octreotide injection
SANDOSTATIN

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has an FDA approved indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently using the requested agent AND is at risk if therapy is changed OR
    B. ONE of the following:
        i. Patient has a diagnosis of acromegaly AND ONE of the following:
            a. Patient is not a candidate for surgical resection or pituitary radiation therapy OR
            b. The requested agent is for adjunctive therapy with pituitary radiation therapy OR
            c. Patient had an inadequate response to surgery or pituitary radiation therapy as indicated by growth hormone levels or serum IGF-1 levels that are above the reference range OR
        ii. Patient has severe diarrhea and/or flushing episodes associated with metastatic carcinoid tumors OR
        iii. Patient has profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors OR
        iv. Patient has a diagnosis of dumping syndrome AND the following:
        a. Patient has tried acarbose or has a documented intolerance, FDA labeled contraindication, or hypersensitivity to acarbose OR
        v. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
2. The dose requested is within the FDA approved or CMS approved compendia dosing for the requested agent and indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Initial approval will be for 6 months, renewal approval will be for 12 months

Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria and has responded to therapy AND
2. ONE of the following:
    A. Patient has a diagnosis of acromegaly AND the following:
        i. Patient has had clinical improvement (e.g. reduction in tumor size, decreased headaches, improved cardiovascular or respiratory symptoms) OR
    B. Patient has severe diarrhea and/or flushing episodes associated with metastatic carcinoid tumors OR
    C. Patient has profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors OR
    D. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
3. The dose requested is within the FDA approved or CMS approved compendia dosing for the requested agent and indication

Prior Authorization Group – **Somatostatin Analogs PA - Sandostatin LAR**

Drug Name(s):
SANDOSTATIN LAR

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. ONE of the following:
    A. Patient has an FDA approved indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently using the requested agent AND is at risk if therapy is changed OR
    B. ONE of the following:
        i. Patient has a diagnosis of acromegaly AND ONE of the following:
            a. Patient is not a candidate for surgical resection or pituitary radiation therapy OR
            b. The requested agent is for adjunctive therapy with pituitary radiation therapy OR
            c. Patient had an inadequate response to surgery or pituitary radiation therapy as indicated by growth hormone levels or serum IGF-1 levels that are above the reference range OR
        ii. Patient has severe diarrhea and/or flushing episodes associated with metastatic carcinoid tumors OR
        iii. Patient has profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors OR
        iv. Patient has a diagnosis of dumping syndrome AND the following:
            a. Patient has tried acarbose or has a documented intolerance, FDA labeled contraindication, or hypersensitivity to acarbose OR
        v. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
2. Patient has responded to and tolerated octreotide for a minimum of 2 weeks AND
3. The dose requested is within the FDA approved or CMS approved compendia dosing for the requested agent and indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Initial approval will be for 6 months, renewal approval will be for 12 months

Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria and has responded to therapy AND
2. ONE of the following:
    A. Patient has a diagnosis of acromegaly AND ONE of the following:
        i. Decrease in growth hormone level to less than 1 ng/mL OR
        ii. Normalized serum IGF-1 level (IGF-1 is within reference laboratory range) OR
        iii. Clinical improvement (e.g. reduction in tumor size, decreased headaches, improved cardiovascular or respiratory symptoms) OR
    B. Patient has severe diarrhea and/or flushing episodes associated with metastatic carcinoid tumors OR
    C. Patient has profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors OR
    D. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
3. The dose requested is within the FDA approved or CMS approved compendia dosing for the requested agent and indication

Prior Authorization Group – **Somatostatin Analogs PA - Somatuline Depot**

Drug Name(s):

SOMATULINE DEPOT

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:

Program applies to new starts only.
Criteria for initial approval require ONE of the following:
1. Patient has an FDA approved indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently using the requested agent OR
2. BOTH of the following:
    A. ONE of the following
        i. Patient has a diagnosis of acromegaly AND ONE of the following:
            a. Patient is not a candidate for surgical resection or pituitary radiation therapy OR
            b. The requested agent is for adjunctive therapy with pituitary radiation therapy OR
            c. Patient had an inadequate response to surgery or pituitary radiation therapy as indicated by growth hormone levels or serum IGF-1 levels that are above the reference range OR
        ii. Patient has a diagnosis of gastroenteropancreatic neuroendocrine tumors AND ONE of the following:
            a. The tumors are unresectable, locally advanced, well or moderately differentiated OR
            b. The tumors have metastasized OR
        iii. Patient has a diagnosis of carcinoid syndrome (i.e. flushing and/or diarrhea) OR
        iv. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
    B. The dose requested is within the FDA approved or CMS approved compendia dosing for the requested agent and indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Initial approval will be for 6 months, renewal approval will be for 12 months

Other Criteria:
Criteria for renewal approval require ONE of the following:
1. Patient has an FDA approved indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently using the requested agent OR
2. Patient has been previously approved for the requested agent through the plan's PA criteria and has responded to therapy AND BOTH of the following:
    A. ONE of the following:
        i. Patient has a diagnosis of acromegaly AND the following:
            a. Patient has had clinical improvement (e.g. reduction in tumor size, decreased headaches, improved cardiovascular or respiratory symptoms) OR
        ii. Patient has a diagnosis of metastatic OR unresectable, locally advanced, well or moderately differentiated gastroenteropancreatic neuroendocrine tumors OR
        iii. Patient has a diagnosis of carcinoid syndrome (i.e. flushing and/or diarrhea) OR
        iv. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
    B. The dose requested is within the FDA approved or CMS approved compendia dosing for the requested agent and indication

Prior Authorization Group – **Somatostatin Analogs PA - Somavert**

Drug Name(s):

SOMAVERT

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:

Criteria for initial approval require BOTH of the following:

1. Patient has a diagnosis of acromegaly AND ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently using the requested agent AND is at risk if therapy is changed OR
    C. BOTH of the following:
        A. ONE of the following:
            a. Patient is not a candidate for surgical resection or pituitary radiation therapy OR
            b. Patient had an inadequate response to surgery or pituitary radiation therapy as indicated by serum IGF-1 levels that are above the reference range AND
        B. ONE of the following:
            a. Patient has tried and failed a prerequisite agent (octreotide or Somatuline Depot) OR
            b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to prerequisite agents AND
2. The dose requested is within the FDA approved dosing for the requested agent and indication

Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's PA criteria and has responded to therapy AND
2. Patient has a diagnosis of acromegaly AND the following:
    A. Patient has had clinical improvement (e.g. reduction in tumor size, decreased headaches, improved cardiovascular or respiratory symptoms) AND
3. The dose requested is within the FDA approved dosing for the requested agent and indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Initial approval will be for 6 months, renewal approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Sovaldi PA**

Drug Name(s):
SOVALDI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The dosing of the requested agent is within the FDA labeled dosing or is AASLD/IDSA guideline supported AND
5. ONE of the following:
    A. There is documentation that the patient is currently being treated with the requested agent OR
    B. Patient has an FDA labeled contraindication or hypersensitivity to the preferred agents: Harvoni (ledipasvir/sofosbuvir) for supported genotypes OR Epclusa (sofosbuvir/velpatasvir) for genotype 2 or 3 OR
    C. Prescriber has submitted documentation based on FDA approved labeling or AASLD/IDSA guidelines to support the use of the non-preferred agent for the patient's diagnosis and genotype over the preferred agents: Harvoni (ledipasvir/sofosbuvir) for supported genotypes OR Epclusa (sofosbuvir/velpatasvir) for genotype 2 or 3

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist

Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported

Other Criteria:

Prior Authorization Group – **Spravato PA**

Drug Name(s):
SPRAVATO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require BOTH of the following:
1. BOTH of following:
    a. Patient has a diagnosis of treatment-resistant depression (TRD) AND
    b. Patient is currently receiving treatment with an oral antidepressant and will continue to receive the antidepressant with the requested agent AND
2. ONE of following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ALL of the following:
        i. Patient has had an inadequate response to at least two different oral antidepressants (e.g., SSRIs, SNRIs) AND
        ii. Prescriber is a specialist (e.g., psychiatrist) or the prescriber has consulted with a specialist AND
        iii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. BOTH of the following:
    a. Patient has a diagnosis of treatment-resistant depression (TRD) AND
    b. Patient is currently receiving treatment with an oral antidepressant and will continue to receive the antidepressant with the requested agent AND
3. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ALL of the following:

i. Patient has shown clinical benefit with the requested agent AND
ii. Prescriber is a specialist (e.g., psychiatrist) or the prescriber has consulted with a specialist AND
iii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Strensiq PA**

Drug Name(s):
STRENSIQ

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has ONE of the following diagnoses:
    a. Perinatal or infantile-onset hypophosphatasia OR
    b. Juvenile-onset hypophosphatasia (HPP) AND
2. Patient has clinical manifestations consistent with hypophosphatasia (e.g. vitamin B6-dependent seizures, skeletal abnormalities: such as rachitic chest deformity leading to respiratory problems or bowed arms/legs, “failure to thrive”) AND
3. Patient has radiographic imaging to support the diagnosis of hypophosphatasia (e.g. infantile rickets, alveolar bone loss, craniosynostosis) AND
4. Patient has confirmation of ALPL gene mutation AND
5. Patient has a measured total serum alkaline phosphatase (ALP) level that is below the normal lab reference range for age and sex AND
6. Patient has ONE of the following:
    a. Elevated urine concentration of phosphoethanolamine (PEA) OR
    b. Elevated serum concentration of pyridoxal 5'-phosphate (PLP) in the absence of vitamin supplements within one week prior to the test OR
    c. Elevated urinary inorganic pyrophosphate (PPi)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan’s PA criteria AND
2. Patient has ONE of the following diagnoses:
    a. Perinatal or infantile-onset hypophosphatasia OR
    b. Juvenile-onset hypophosphatasia (HPP) AND
3. Patient has responded to treatment with the requested agent as evidenced by an improvement and/or stabilization respiratory status, growth, or radiographic findings

Age Restrictions:

Prescriber Restrictions:
Prescriber is an endocrinologist, a specialist in metabolic or bone disease, or the prescriber has consulted with an endocrinologist or a specialist in metabolic or bone disease

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Substrate Reduction Therapy PA - Cerdelga**

Drug Name(s):
CERDELGA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Gaucher disease type 1 confirmed by ONE of the following:
    A. A baseline glucocerebrosidase enzyme activity of less than 15% of mean normal in peripheral blood leukocytes, fibroblasts, or other nucleated cells OR
    B. Confirmation of genetic mutation of GBA gene with two disease-causing alleles AND
2. Patient is a CYP2D6 extensive metabolizer (EMs), intermediate metabolizer (IMs), or poor metabolizer (PMs) established by a genetic test AND
3. Prescriber has drawn baseline levels of hemoglobin, platelets, liver volume, and spleen volume AND
4. Prior to any treatment for the intended diagnosis, the patient has had ONE of the following:
    A. Anemia (defined as mean hemoglobin (Hb) level below the testing laboratory's lower limit of the normal range based on age and gender) OR
    B. Thrombocytopenia (defined as platelet count of less than 100,000 per microliter) OR
    C. Hepatomegaly OR
    D. Splenomegaly OR
    E. Growth failure (i.e. growth velocity is below the standard mean for age) OR
    F. Evidence of bone disease with other causes ruled out

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of Gaucher disease type 1 AND
3. Patient has shown improvement and/or stabilization from baseline in ONE of the following:
    A. Spleen volume OR
    B. Hemoglobin level OR

C. Liver volume OR
D. Platelet count OR
E. Growth OR
F. Bone pain or crisis

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. endocrinologist, geneticist, hematologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Substrate Reduction Therapy PA - Miglustat**

Drug Name(s):
miglustat 100 mg capsule
ZAVESCA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Gaucher disease type 1 confirmed by ONE of the following:
    A. A baseline glucocerebrosidase enzyme activity of less than 15% of mean normal in peripheral blood leukocytes, fibroblasts, or other nucleated cells OR
    B. Confirmation of genetic mutation of GBA gene with two disease-causing alleles AND
2. ONE of the following:
    A. Patient's medication history indicates use of at least ONE enzyme replacement therapy (i.e. Cerezyme, Vpriv, Elelyso) OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to at least ONE enzyme replacement therapy AND
3. Prescriber has drawn baseline levels of hemoglobin, platelets, liver volume, and spleen volume AND
4. Prior to any treatment for the intended diagnosis, the patient has had ONE of the following:
    A. Anemia (defined as mean hemoglobin (Hb) level below the testing laboratory's lower limit of the normal range based on age and gender) OR
    B. Thrombocytopenia (defined as platelet count of less than 100,000 per microliter) OR
    C. Hepatomegaly OR
    D. Splenomegaly OR
    E. Growth failure (i.e. growth velocity is below the standard mean for age) OR
    F. Evidence of bone disease with other causes ruled out

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of Gaucher disease type 1 AND

3. Patient has shown improvement and/or stabilization from baseline in ONE of the following:

A. Spleen volume OR
B. Hemoglobin level OR
C. Liver volume OR
D. Platelet count OR
E. Growth OR
F. Bone pain or crisis

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. endocrinologist, geneticist, hematologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Sunosi PA**

Drug Name(s):
SUNOSI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of excessive daytime sleepiness associated with narcolepsy AND BOTH of the following:
        i. ONE of the following:
            1. Patient's medication history indicates the use of modafinil or armodafinil OR
            2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to modafinil or armodafinil AND
        ii. ONE of the following:
            1. Patient's medication history indicates the use of ONE standard stimulant agent (e.g., methylphenidate) OR
            2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE standard stimulant agent (e.g., methylphenidate) OR
    B. Patient has a diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea (OSA) AND ONE of the following:
        i. Patient's medication history indicates the use of modafinil or armodafinil OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to modafinil or armodafinil AND
2. Patient is not currently taking a monoamine oxidase (MAO) inhibitor (e.g., phenelzine, tranylcypromine) or the patient has not recently (within 14 days) taken a MAO inhibitor

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of following:
    A. Patient has a diagnosis of excessive daytime sleepiness associated with narcolepsy OR

B. Patient has a diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea (OSA) AND

3. Patient is not currently taking a monoamine oxidase (MAO) inhibitor (e.g., phenelzine, tranylcypromine) or the patient has not recently (within 14 days) taken a MAO inhibitor AND

4. Patient has shown clinical benefit with the requested agent

Age Restrictions:

Patient is 18 years of age or over

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Symdeko PA**

Drug Name(s):
SYMDEKO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. ONE of the following:
    A. Patient has the presence of the F508del mutation on both alleles (homozygous) of the CFTR gene confirmed by genetic testing OR
    B. Patient has ONE of the CFTR gene mutations as indicated in the FDA label as confirmed by genetic testing AND
3. Patient has had pre-therapeutic/baseline FEV1 levels measured AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another CFTR agent [e.g. Kalydeco (ivacaftor), Orkambi (lumacaftor/ivacaftor)] OR
    B. Patient is currently being treated with another CFTR agent AND will discontinue the other CFTR agent prior to starting the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of cystic fibrosis AND
3. Patient has shown improvement or stabilization in FEV1 from pretreatment levels with the requested agent AND
4. ONE of the following:
    A. Patient is NOT currently being treated with another CFTR agent [e.g. Kalydeco (ivacaftor), Orkambi (lumacaftor/ivacaftor)] OR
    B. Patient is currently being treated with another CFTR agent AND will discontinue the other CFTR agent prior to starting the requested agent

Age Restrictions:
Patient is 6 years of age or over

Prescriber Restrictions:
Prescriber is a specialist (e.g. cystic fibrosis, pulmonologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Symproic PA**

Drug Name(s):
SYMPROIC

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has opioid-induced constipation (OIC) and chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment AND
2. Patient has chronic use of an opioid agent in the past 90 days AND
3. ONE of the following:
    A. Patient has a medication history that includes lactulose or polyethylene glycol 3350 OR
    B. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to lactulose or polyethylene glycol 3350

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Tavalisse PA**

Drug Name(s):
TAVALISSE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of chronic immune (idiopathic) thrombocytopenia (ITP) AND
2. ONE of the following:
    A. Patient has had an insufficient response to corticosteroids or immunoglobulins (IVIg or anti-D) or another thrombopoietin receptor agonist (e.g., Nplate, Promacta) OR
    B. Patient has had an insufficient response to a splenectomy OR
    C. BOTH of the following:
        i. Patient is NOT a candidate for splenectomy AND
        ii. Patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to corticosteroids, immunoglobulins (IVIg or anti-D), or another thrombopoietin receptor agonist (e.g., Nplate, Promacta)

Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's prior authorization criteria AND
2. Patient has a diagnosis of chronic immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following:
    i. Patient's platelet count is 50 x 109/L or greater OR
    ii. Patient's platelet count has increased sufficiently to avoid clinically important bleeding

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal

Other Criteria:

Prior Authorization Group – **Technivie PA**

Drug Name(s):
TECHNIVIE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The dosing of the requested agent is within the FDA labeled dosing or is AASLD/IDSA guideline supported AND
5. ONE of the following:
    A. There is documentation that the patient is currently being treated with the requested agent OR
    B. Patient has an FDA labeled contraindication or hypersensitivity to the preferred agent: Harvoni (ledipasvir/sofosbuvir) for supported genotypes OR
    C. Prescriber has submitted documentation based on FDA approved labeling or AASLD/IDSA guidelines to support the use of the non-preferred agent for the patient's diagnosis and genotype over the preferred agent: Harvoni (ledipasvir/sofosbuvir) for supported genotypes

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist

Coverage Duration:

Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported

Other Criteria:

Prior Authorization Group – **Tegsedi PA**

Drug Name(s):
TEGSEDI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis AND
2. The dose requested is within the FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. neurologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Tetrabenazine PA**

Drug Name(s):
tetrabenazine tablet
XENAZINE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of chorea associated with Huntington's disease OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. If the patient has a current diagnosis of depression, the patient is being treated for depression AND
3. If the patient has a diagnosis of suicidal ideation and/or behavior, the patient must not be actively suicidal AND
4. Patient is NOT receiving a monoamine oxidase inhibitor (MAOI) OR the patient's MAOI will be discontinued at least 14 days before starting therapy with the requested agent AND
5. Patient is NOT receiving reserpine OR the patient's reserpine will be discontinued at least 20 days before starting therapy with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Topical Doxepin PA**

Drug Name(s):
DOXEPIN 5% cream
PRUDOXIN
ZONALON

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require the following:
1. ONE of the following:
    a. Patient has a diagnosis of moderate pruritus associated with atopic dermatitis AND ONE of the following:
        i. Patient's medication history includes the use of a topical corticosteroid (e.g. clobetasol, hydrocortisone, triamcinolone) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a topical corticosteroid OR
    b. Patient has a diagnosis of moderate pruritus associated with lichen simplex chronicus AND ONE of the following:
        i. Patient's medication history includes the use of a topical corticosteroid (e.g. clobetasol, hydrocortisone, triamcinolone) OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a topical corticosteroid

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 8 days

Other Criteria:

Prior Authorization Group – **Topical NSAID PA - Flector**

Drug Name(s):
DICLOFENAC 1.3% patch
FLECTOR

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. Patient's medication history includes use of any prescription oral NSAID (non-steroidal anti-inflammatory drug) OR
    b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to any prescription oral NSAID

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
3 months for acute pain, 12 months for all other diagnoses

Other Criteria:

Prior Authorization Group – **Topical NSAID PA - Pennsaid**

Drug Name(s):
diclofenac 1.5% solution
PENNSAID

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. Patient's medication history includes use of any prescription oral NSAID (non-steroidal anti-inflammatory drug) OR
    b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to any prescription oral NSAID

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
3 months for acute pain, 12 months for all other diagnoses

Other Criteria:

Prior Authorization Group – **Topical NSAID PA - Voltaren**

Drug Name(s):
diclofenac 1% gel
VOLTAREN 1% gel

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. Patient's medication history includes use of any prescription oral NSAID (non-steroidal anti-inflammatory drug) OR
    b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to any prescription oral NSAID

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
3 months for acute pain, 12 months for all other diagnoses

Other Criteria:

Prior Authorization Group – **Trelstar PA**

Drug Name(s):
TRELSTAR
TRELSTAR MIXJECT

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
This program applies to new starts only.
Criteria for approval require ALL of the following:
1. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. BOTH of the following:
        i. Patient is NOT currently being treated with the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindication(s) to the requested agent AND
3. The dose requested is within the FDA labeled or CMS approved compendia dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Trientine PA**

Drug Name(s):
SYPRINE
trientine capsule

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of Wilson's disease confirmed by ONE of the following:
    a. Confirmation of genetic mutation of the ATP7B gene OR
    b. Patient has TWO of the following:
        i. Presence of hepatic abnormality (e.g. acute liver failure, cirrhosis, fatty liver)
        ii. Presence of Kayser-Fleischer rings
        iii. Serum ceruloplasmin level less than 20 mg/dL
        iv. Basal urinary copper excretion greater than 40 mcg/24 hours or the testing laboratory's upper limit of normal
        v. Hepatic parenchymal copper content greater than 40 mcg/g dry weight
        vi. Presence of neurological symptoms (e.g. dystonia, hypertonia, rigidity with tremors, dysarthria, muscle spasms, dysphasia, polyneuropathy, dysautonomia) AND
2. ONE of the following:
    a. Patient's medication history indicates use of a penicillamine (e.g. Depen) OR
    b. Patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to a penicillamine

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of Wilson's disease AND
3. Patient has responded to treatment with the requested agent as evidenced by ONE of the following:
    a. Improvement and/or stabilization in hepatic abnormality OR
    b. Reduction in Kayser-Fleischer rings OR

c. Improvement and/or stabilization in neurological symptoms (e.g. dystonia, hypertonia, rigidity with tremors, dysarthria, muscle spasms, dysphasia, polyneuropathy, dysautonomia) OR
d. Basal urinary copper excretion greater than 200 mcg/24 hours

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. gastroenterologist, hepatologist, or neurologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Trulance PA**

Drug Name(s):
TRULANCE

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has ONE of the following diagnoses:
    a. Chronic idiopathic constipation with documentation of symptoms for at least 3 months OR
    b. Irritable bowel syndrome with constipation with documentation of symptoms for at least 3 months AND
2. ONE of the following:
    a. Patient has a medication history that includes lactulose or polyethylene glycol 3350 OR
    b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to lactulose or polyethylene glycol 3350

Age Restrictions:
Patient is 18 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Tymlos PA**

Drug Name(s):
TYMLOS

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
An increased baseline risk for osteosarcoma

Required Medical:
Criteria for approval require ALL of the following:
1. Patient is a postmenopausal female with a diagnosis of osteoporosis AND ONE of the following:
    a. Patient has a history of vertebral fracture(s), or low trauma or fragility fracture(s) [e.g. prior fracture from minor trauma such as falling from standing height or less] within the past 5 years OR
    b. Patient has a T-score that is -2.5 or lower (greater than or equal to 2.5 SD below the mean BMD value for a young adult) AND ONE of the following:
        i. Patient has failed either a bisphosphonate or SERM OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate or SERM AND
2. ONE of the following:
    a. Patient is not receiving concomitant bisphosphonate, SERM, Forteo (teriparatide), Prolia (denosumab), or Xgeva (denosumab) therapy within the past 90 days OR
    b. Prescriber indicates that the patient will discontinue the current bisphosphonate, SERM, Forteo (teriparatide), Prolia (denosumab), or Xgeva (denosumab) therapy prior to initiating therapy with the requested agent AND
3. The dose requested is within the FDA approved labeling AND
4. The total duration of treatment with Tymlos has not exceeded 2 years

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
No prior Tymlos use approve 2 yrs, Prior Tymlos use approve remainder of 2 yrs of total therapy

Other Criteria:

Prior Authorization Group – **URAT1 Inhibitor PA - Zurampic**

Drug Name(s):
ZURAMPIC

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. The requested agent is for the treatment of hyperuricemia associated with gout AND
2. BOTH of the following:
    a. Patient has NOT achieved target serum uric acid levels with a xanthine oxidase inhibitor alone [e.g. allopurinol or Uloric (febuxostat)] AND
    b. Patient will be taking a xanthine oxidase inhibitor [e.g. allopurinol or Uloric (febuxostat)] concurrently with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Urea Cycle Disorders PA - Buphenyl**

Drug Name(s):
BUPHENYL
sodium phenylbutyrate powder, tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of ONE of the following:
    a. Urea cycle disorder with neonatal-onset involving deficiencies of carbamylphosphate synthetase, ornithine transcarbamylase, or argininosuccinic acid synthetase OR
    b. Urea cycle disorder with late-onset and history of hyperammonemic encephalopathy involving deficiencies of carbamylphosphate synthetase, ornithine transcarbamylase, or argininosuccinic acid synthetase AND
2. The dose requested is within the FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. geneticist, metabolic disorders) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Urea Cycle Disorders PA - Ravicti**

Drug Name(s):
RAVICTI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of urea cycle disorder and the requested agent will be used for chronic management AND
2. The dose requested is within the FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. geneticist, metabolic disorders) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Viekira PA**

Drug Name(s):
VIEKIRA PAK

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The dosing of the requested agent is within the FDA labeled dosing or is AASLD/IDSA guideline supported AND
5. If genotype 1, the patient's subtype has been identified and provided AND
6. ONE of the following:
    A. There is documentation that the patient is currently being treated with the requested agent OR
    B. Patient has an FDA labeled contraindication or hypersensitivity to the preferred agent: Harvoni (ledipasvir/sofosbuvir) for supported genotypes OR
    C. Prescriber has submitted documentation based on FDA approved labeling or AASLD/IDSA guidelines to support the use of the non-preferred agent for the patient's diagnosis and genotype over the preferred agent: Harvoni (ledipasvir/sofosbuvir) for supported genotypes

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist

Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported

Other Criteria:

Prior Authorization Group – **Viekira XR PA**

Drug Name(s):
VIEKIRA XR

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The dosing of the requested agent is within the FDA labeled dosing or is AASLD/IDSA guideline supported AND
5. If genotype 1, the patient's subtype has been identified and provided AND
6. ONE of the following:
    A. There is documentation that the patient is currently being treated with the requested agent OR
    B. Patient has an FDA labeled contraindication or hypersensitivity to the preferred agent: Harvoni (ledipasvir/sofosbuvir) for supported genotypes OR
    C. Prescriber has submitted documentation based on FDA approved labeling or AASLD/IDSA guidelines to support the use of the non-preferred agent for the patient's diagnosis and genotype over the preferred agent: Harvoni (ledipasvir/sofosbuvir) for supported genotypes

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist

Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported

Other Criteria:

Prior Authorization Group – **Voriconazole PA**

Drug Name(s):
VFEND
VFEND IV
voriconazole injection, suspension, tablet

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for initial approval require ONE of the following:
A. Patient has a diagnosis of invasive Aspergillus OR
B. Patient has an infection caused by Scedosporium apiospermum or Fusarium species OR
C. Patient has a diagnosis of esophageal candidiasis or candidemia in nonneutropenic patient AND patient has tried fluconazole or an alternative antifungal agent OR patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to fluconazole or an alternative antifungal agent OR
D. Patient has a diagnosis of blastomycosis AND patient has tried itraconazole OR patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to itraconazole OR
E. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida AND patient is severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR
F. Patient has another indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
One month for esophageal candidiasis, 6 months for other indications

Other Criteria:

Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. ONE of the following:

A. Patient has a diagnosis of invasive Aspergillus, Scedosporium apiospermum, Fusarium, esophageal candidiasis, candidemia in nonneutropenic patient or blastomycosis and patient has continued indicators of active disease (e.g. continued radiologic findings, positive cultures, positive serum galactomannan assay for Aspergillus) OR

B. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida and patient continues to be severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR

C. Patient has another indication that is supported in CMS approved compendia for the requested agent

Prior Authorization Group – **Vosevi PA**

Drug Name(s):
VOSEVI

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The dosing of the requested agent is within the FDA labeled dosing or is AASLD/IDSA guideline supported AND
5. If genotype 1, the patient's subtype has been identified and provided

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g. gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist

Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported

Other Criteria:

Prior Authorization Group – **Vyndamax PA**

Drug Name(s):
VYNDAMAX

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) AND
2. The requested agent will be used to reduce cardiovascular mortality and cardiovascular-related hospitalization AND
3. Vyndamax (tafamidis) and Vyndaqel (tafamidis meglumine) will not be used concurrently with each other

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) AND
3. The requested agent will be used to reduce cardiovascular mortality and cardiovascular-related hospitalization AND
4. Patient has shown clinical benefit with the requested agent AND
5. Vyndamax (tafamidis) and Vyndaqel (tafamidis meglumine) will not be used concurrently with each other

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g., cardiologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Vyndaqel PA**

Drug Name(s):
VYNDAQEL

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) AND
2. The requested agent will be used to reduce cardiovascular mortality and cardiovascular-related hospitalization AND
3. Vyndamax (tafamidis) and Vyndaqel (tafamidis meglumine) will not be used concurrently with each other

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) AND
3. The requested agent will be used to reduce cardiovascular mortality and cardiovascular-related hospitalization AND
4. Patient has shown clinical benefit with the requested agent AND
5. Vyndamax (tafamidis) and Vyndaqel (tafamidis meglumine) will not be used concurrently with each other

Age Restrictions:

Prescriber Restrictions:
Prescriber is a specialist (e.g., cardiologist) or the prescriber has consulted with a specialist

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Xermelo PA**

Drug Name(s):
XERMELO

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of carcinoid syndrome diarrhea AND
2. Patient has tried treatment with a somatostatin analog (e.g. Sandostatin (octreotide), Sandostatin LAR (octreotide), Somatuline depot) and had an inadequate response AND
3. Patient will use the requested agent in combination with a somatostatin analog (e.g. Sandostatin (octreotide), Sandostatin LAR (octreotide), Somatuline depot)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. Patient has a diagnosis of carcinoid syndrome diarrhea AND
3. Patient has had clinical improvement (e.g. reduction in the average number of daily bowel movements) with the requested agent AND
4. Patient will use the requested agent in combination with a somatostatin analog (e.g. Sandostatin (octreotide), Sandostatin LAR (octreotide), Somatuline depot)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Xgeva PA**

Drug Name(s):
XGEVA

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of multiple myeloma AND ALL of the following:
        i. The requested agent will be used for the prevention of skeletal-related events AND
        ii. ONE of the following:
            1. Patient has tried and failed zoledronic acid (Zometa) OR
            2. Patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to zoledronic acid (Zometa) AND
        iii. ONE of the following:
            1. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR
            2. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR
            3. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR
    B. Patient has a solid tumor cancer diagnosis (e.g. thyroid, non-small cell lung, kidney cancer, prostate cancer, or breast cancer) AND ALL of the following:
        i. The requested agent will be used for the prevention of skeletal-related events AND
        ii. Patient has bone metastases AND
        iii. ONE of the following:
            1. Patient has tried and failed zoledronic acid (Zometa) OR
            2. Patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to zoledronic acid (Zometa) AND
        iv. ONE of the following:

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

Criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:
C. Patient has a diagnosis of giant cell tumor of bone AND ONE of the following:
i. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR
ii. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR
iii. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR
D. Patient has a diagnosis of hypercalcemia of malignancy AND ONE of the following:
i. Patient has tried and failed zoledronic acid (Zometa) OR
ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to zoledronic acid (Zometa) AND
2. ONE of the following:
A. Patient is NOT receiving concomitant Prolia (denosumab) therapy within the past 90 days OR
B. Patient will discontinue the current Prolia (denosumab) therapy prior to initiating therapy with the requested agent AND
3. The requested dose is within the FDA labeled dosing for the requested indication

Prior Authorization Group – **Xolair PA**

Drug Name(s):
XOLAIR

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for initial approval require ONE of the following:
1. Patient has a diagnosis of asthma AND ALL of the following:
    a. If the patient is 6 to less than 12 years of age, the patient meets BOTH of the following:
        i. Patient's pretreatment IgE level is 30 IU/mL to 1300 IU/mL AND
        ii. Patient's weight is 20 kg to 150 kg AND
    b. If the patient is 12 years of age or over, the patient meets ALL of the following:
        i. Patient's pretreatment IgE level is 30 IU/mL to 700 IU/mL AND
        ii. Patient's weight is 30 kg to 150 kg AND
        iii. Patient has a baseline FEV1 less than 80% predicted AND
    c. Allergic asthma has been confirmed by positive skin test or in vitro reactivity test (RAST) to a perennial aeroallergen AND
    d. There is evidence of a claim that the patient is currently using an inhaled corticosteroid within the past 90 days OR the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to inhaled corticosteroid AND
    e. ONE of the following:
        i. There is evidence of a claim that the patient is currently using a long-acting beta-2 agonist within the past 90 days OR the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to long-acting beta-2 agonist OR
        ii. There is evidence of a claim that the patient is currently using a leukotriene modifier or theophylline within the past 90 days OR the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to a leukotriene modifier or theophylline AND
    f. Patient is experiencing exacerbations of asthma symptoms AND
    g. The requested dose is within the FDA labeled dose OR

Initial criteria continues: see Other Criteria

Age Restrictions:

For diagnosis of asthma, patient is 6 years of age or over. For diagnosis of chronic idiopathic urticaria, patient is 12 years of age or over.

Prescriber Restrictions:

Coverage Duration:
Initial: 24 weeks for asthma and chronic idiopathic urticaria Renewal: 12 months

Other Criteria:
2. Patient has a diagnosis of chronic idiopathic urticaria AND ALL of the following:
    a. Patient has a history of chronic idiopathic urticaria for at least 6 months AND
    b. Patient has a history of hives and itching AND
    c. ONE of the following:
        i. There is evidence of a claim that the patient is currently on maximum tolerable H1 antihistamine therapy within the past 90 days OR
        ii. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to H1 antihistamine therapy AND
    d. The requested dose is within the FDA labeled dose

Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's PA criteria AND
2. ONE of the following:
    a. Patient has a diagnosis of asthma AND ALL of the following:
        i. Patient's weight is within the FDA indicated range for their age (i.e. 20 kg to 150 kg for patients age 6 to less than 12 years and 30 kg to 150 kg for patients 12 years of age or over) AND
        ii. Patient does not have clinical worsening defined as ONE of the following:
            1. Increase in inhaled corticosteroid use
            2. Treatment with systemic corticosteroids
            3. Increased use of short acting beta-2 agonist rescue medication
            4. Unscheduled care visits (urgent care, ER, or hospitalizations) due to exacerbations AND
        iii. ONE of the following:
            1. There is evidence of a claim that the patient is currently on standard therapy (such as a combination of an inhaled corticosteroid, long acting beta-2 agonist, leukotriene receptor antagonist, theophylline, oral corticosteroid or an oral beta-2 agonist tablet) within the past 90 days OR

2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ALL standard therapies AND

iv. The requested dose is within the FDA labeled dose OR

b. Patient has a diagnosis of chronic idiopathic urticaria AND BOTH of the following:

i. Improvement in symptoms (e.g. number of hives, size of hives, reduction in itching) AND

ii. The requested dose is within the FDA labeled dose

Prior Authorization Group – **Xyrem PA**

Drug Name(s):
XYREM

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ONE of the following:
A. Patient has a diagnosis of narcolepsy with cataplexy OR
B. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness AND BOTH of the following:
- i. ONE of the following:
  - a. Patient is under 18 years of age OR
  - b. ONE of the following:
    1. Patient's medication history indicates the use of modafinil or armodafinil OR
    2. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to modafinil or armodafinil AND
- ii. ONE of the following:
  - a. Patient's medication history indicates the use of ONE standard stimulant agent (e.g. methylphenidate) OR
  - b. Patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE standard stimulant agent (e.g. methylphenidate)

Age Restrictions:
Patient is 7 years of age or over

Prescriber Restrictions:

Coverage Duration:
Approval will be for 12 months

Other Criteria:

Prior Authorization Group – **Zepatier PA**

Drug Name(s):
ZEPATIER

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:
FDA labeled contraindication(s) to the requested agent

Required Medical:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The dosing of the requested agent is within the FDA labeled dosing or is AASLD/IDSA guideline supported AND
5. If genotype 1, the patient's subtype has been identified and provided AND
6. If genotype 1a, the prescriber has tested the patient for the presence of virus with NS5A resistance-associated polymorphisms AND
7. ONE of the following:
    A. There is documentation that the patient is currently being treated with the requested agent OR
    B. Patient has an FDA labeled contraindication or hypersensitivity to the preferred agents: Harvoni (ledipasvir/sofosbuvir) for supported genotypes OR Epclusa (sofosbuvir/velpatasvir) for genotype 3 OR
    C. Prescriber has submitted documentation based on FDA approved labeling or AASLD/IDSA guidelines to support the use of the non-preferred agent for the patient's diagnosis and genotype over the preferred agents: Harvoni (ledipasvir/sofosbuvir) for supported genotypes OR Epclusa (sofosbuvir/velpatasvir) for genotype 3

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist (e.g. gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist

Coverage Duration:

Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported

Other Criteria:

Prior Authorization Group – **Zyclara PA**

Drug Name(s):
IMIQUIMOD PUMP 3.75%
ZYCLARA
ZYCLARA PUMP

Covered Uses:
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of actinic keratosis OR
2. Patient has a diagnosis of external genital and/or perianal warts/condyloma acuminata AND the requested agent is Zyclara 3.75%

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:
8 weeks for ext. genital/perianal warts/condyloma acuminata, 6 weeks for actinic keratosis

Other Criteria: