Solis Health Plans Medicare Part D Plan

Prior Authorization Criteria
Last Updated 8/1/2024

Products Affected

- *adapalene 0.1% cream*
- *adapalene/benzoyl peroxide 0.1-2.5% gel*
- *tretinoin 0.025% cream*
- *tretinoin 0.05% cream*
- *adapalene 0.3% gel*
- *tretinoin 0.01% gel*
- *tretinoin 0.025% gel*
- *tretinoin 0.1% cream*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ACTEMRA 162MG/0.9ML AUTO-INJECTOR
- ACTEMRA 162MG/0.9ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Enbrel, b) Humira or Hadlima, c) Rinvoq OR d) Xeljanz. For polyarticular juvenile idiopathic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel OR c) Xeljanz. For giant cell arteritis (all requests): Trial of other agents not required. For systemic sclerosis-associated interstitial lung disease (initial requests): a) Diagnosis is confirmed with documentation provided of both of the following: i) HRCT scan AND ii) pulmonary function tests AND b) Trial of mycophenolate was ineffective or not tolerated. For systemic juvenile idiopathic arthritis (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, systemic juvenile idiopathic arthritis, and giant cell arteritis: Prescribed by, or in consultation with, a rheumatology specialist. For systemic sclerosis-associated interstitial lung disease: Prescribed by, or in consultation with, a pulmonologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ACTIMMUNE 2000000UNIT/0.5ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ADBRY 150MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For atopic dermatitis (initial requests): Two of the following were ineffective or not tolerated: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant. For atopic dermatitis (continuation requests): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For atopic dermatitis (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

Products Affected

- *alyq 20mg tab*
- *tadalafil 20mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ADEMPAS 0.5MG TAB
- ADEMPAS 1MG TAB
- ADEMPAS 2MG TAB
- ADEMPAS 1.5MG TAB
- ADEMPAS 2.5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For all indications: Diagnosis confirmed by right heart catheterization. For pulmonary arterial hypertension: Both of the following were ineffective or not tolerated: one ERA (ambrisentan, bosentan or macitentan (Opsumit)) AND one PDE5-inhibitor (sildenafil or tadalafil). C) For persistent/recurrent chronic thromboembolic pulmonary hypertension (WHO Group 4): Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *everolimus 10mg tab (New Starts Only)*
- *everolimus 2mg tab for oral susp (New Starts Only)*
- *everolimus 5mg tab (New Starts Only)*
- *everolimus 7.5mg tab (New Starts Only)*
- *everolimus 2.5mg tab (New Starts Only)*
- *everolimus 3mg tab for oral susp (New Starts Only)*
- *everolimus 5mg tab for oral susp (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- AIMOVIG 140MG/ML AUTO-INJECTOR
- AIMOVIG 70MG/ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Both of the following: A) Member has 4 or more migraine days per month for the previous 3 months or longer AND B) An 8-week or greater trial of two of the three following drug classes was ineffective or not tolerated: a) anticonvulsants, b) vasoactive agents, OR c) antidepressants. For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- AKEEGA 500-100MG TAB (New Starts Only)
- AKEEGA 500-50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ALECENSA 150MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of ALK-positive disease.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *nitazoxanide 500mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For diarrhea due to giardiasis: One of the following was ineffective or not tolerated: a) metronidazole OR b) tinidazole. For diarrhea due to cryptosporidiosis: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ARALAST 1000MG INJ
- PROLASTIN 1000MG INJ
- GLASSIA 1000MG/50ML INJ
- ZEMAIRA 1000MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) Diagnosis of congenital alpha1-antitrypsin deficiency is confirmed by both of the following: a) circulating baseline alpha1-antitrysin level is below the standard protective threshold (less than 11 micromol/L OR less than 50 mg per deciliter by nephelometry) AND b) high risk alpha1-antitrypsin deficiency genotype (SS, SZ, ZZ, or null/null) AND B) Prescriber attests that member does not have IgA deficiency with known anti-IgA antibody.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ALUNBRIG 180MG TAB (New Starts Only)
- ALUNBRIG 30MG TAB (New Starts Only)
- ALUNBRIG 90MG TAB (New Starts Only)
- ALUNBRIG INITIATION PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of ALK-positive disease.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- APTIOM 200MG TAB (New Starts Only)
- APTIOM 400MG TAB (New Starts Only)
- APTIOM 600MG TAB (New Starts Only)
- APTIOM 800MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ARCALYST 220MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ARIKAYCE 590MG/8.4ML INH SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist or pulmonologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– AUGTYRO 40MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of ROS1-positive disease.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– AURYXIA 210MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- AUSTEDO 12MG ER TAB
- AUSTEDO 24MG ER TAB
- AUSTEDO 6MG ER TAB
- AUSTEDO 9MG TAB
- AUSTEDO 12MG TAB
- AUSTEDO 6-12-24MG XR TAB TITRATION PACK
- AUSTEDO 6MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For tardive dyskinesia (initial requests): A) One of the following: i) Member has failed to respond to a change in current antidopaminergic therapy OR ii) Member is unable to switch current antidopaminergic therapy OR iii) Member has symptoms of tardive dyskinesia and is not using antidopaminergic therapy AND B) Member has a functional disability due to tardive dyskinesia. For chorea associated with Huntington's disease (initial requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or psychiatrist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- AYVAKIT 100MG TAB (New Starts Only)
- AYVAKIT 200MG TAB (New Starts Only)
- AYVAKIT 25MG TAB (New Starts Only)
- AYVAKIT 300MG TAB (New Starts Only)
- AYVAKIT 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For unresectable or metastatic gastrointestinal stromal tumor: Documentation is provided of PDGFRA exon 18 mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- BALVERSA 3MG TAB (New Starts Only)
- BALVERSA 4MG TAB (New Starts Only)
- BALVERSA 5MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of susceptible FGFR3 genetic alteration.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– BAXDELA 450MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 6 months.
Other Criteria	

Products Affected

- BENLYSTA 200MG/ML AUTO-INJECTOR
- BENLYSTA 200MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For systemic lupus erythematosus initial requests: Two of the following were ineffective or not tolerated: a) hydroxychloroquine, b) methotrexate, c) azathioprine, d) mycophenolate OR e) a corticosteroid. For all requests: Prescriber attests that member does not have severe active CNS lupus AND member is not taking other biologics. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatology specialist, nephrologist, or dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For lupus erythematosus initial therapy: Diagnosis of active systemic lupus erythematosus is confirmed by one of the following: A) anti-double stranded DNA value greater than 30 IU/mL OR B) low complement (C3/C4) OR C) positive for anti-Smith antibodies. For systemic lupus erythematosus (all requests): Will not be given in combination with other biologics. For active lupus nephritis (all requests): Will not be used in combination with voclosporin (Lupkynis).

Products Affected

– BESREMI 500MCG/ML SYRINGE (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	One of the following was ineffective or not tolerated: A) hydroxyurea OR B) peginterferon alfa-2a.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- BOSULIF 100MG CAP (New Starts Only)
- BOSULIF 100MG TAB (New Starts Only)
- BOSULIF 400MG TAB (New Starts Only)
- BOSULIF 500MG TAB (New Starts Only)
- BOSULIF 50MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- BRAFTOVI 75MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate BRAF V600E or V600K mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- BRIVIACT 100MG TAB (New Starts Only)
- BRIVIACT 10MG/ML ORAL SOLN (New Starts Only)
- BRIVIACT 50MG TAB (New Starts Only)
- BRIVIACT 10MG TAB (New Starts Only)
- BRIVIACT 25MG TAB (New Starts Only)
- BRIVIACT 75MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– BRONCHITOL 40MG INH POWDER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– BRUKINSA 80MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– BYDUREON 2MG/0.85ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- CABLIVI 11MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) Member has received or will receive the first dose of caplacizumab while undergoing plasma exchange for acquired thrombotic thrombocytopenic purpura. B) Prescriber attests that patient will be monitored and therapy continued beyond 30 days post-plasma exchange only if ADAMTS23 levels remain less than 10%.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for 4 months.
Other Criteria	

Products Affected

- CABOMETYX 20MG TAB (New Starts Only)
- CABOMETYX 40MG TAB (New Starts Only)
- CABOMETYX 60MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *calcipotriene 0.005% cream*
- *calcipotriene 0.005% ointment*
- CALCIPOTRIENE 0.005% TOPICAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- CALQUENCE 100MG CAP (New Starts Only)
- CALQUENCE 100MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- CAMZYOS 10MG CAP
- CAMZYOS 15MG CAP
- CAMZYOS 2.5MG CAP
- CAMZYOS 5MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Member is symptomatic despite a maximally tolerated dose of one of the following: a) a beta blocker OR b) a non-dihydropyridine calcium channel blocker. For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a cardiologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- CAPLYTA 10.5MG CAP (New Starts Only)
- CAPLYTA 21MG CAP (New Starts Only)
- CAPLYTA 42MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For schizophrenia: Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, OR f) lurasidone. For bipolar depression: Both of the following were ineffective or not tolerated: a) lurasidone AND b) quetiapine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- CAPRELSA 100MG TAB (New Starts Only)
- CAPRELSA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *carglumic acid 200mg tab for oral susp*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– CAYSTON 75MG INH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– CERDELGA 84MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For all requests: Will not be used in combination with imiglucerase (Cerezyme)

Products Affected

- CIBINQO 100MG TAB
- CIBINQO 200MG TAB
- CIBINQO 50MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For atopic dermatitis (initial requests): Two of the following were ineffective or not tolerated: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant. For atopic dermatitis (continuation requests): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For atopic dermatitis (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

Products Affected

- CIMZIA 200MG INJ
- CIMZIA 200MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel c) Rinvoq OR d) Xeljanz. For ankylosing spondylitis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Taltz d) Rinvoq OR e) Xeljanz. For psoriatic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Taltz, d) Stelara, e) Otezla, f) Skyrizi, g) Tremfya, h) Rinvoq OR i) Xeljanz. For plaque psoriasis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Taltz, d) Skyrizi, e) Stelara, f) Tremfya OR g) Otezla. For Crohn's disease (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Stelara, c) Skyrizi, OR d) Rinvoq. For Non-radiographic axial spondyloarthritis (initial requests): Trial of two non-steroidal anti-inflammatory drugs (NSAIDs) was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, psoriatic arthritis, non-radiographic axial spondyloarthritis or ankylosing spondylitis: Prescribed by, or in consultation, with a rheumatology specialist. For Crohn's disease: Prescribed by, or in consultation with, a gastroenterologist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- COMETRIQ CAP 100MG DAILY DOSE PACK (New Starts Only)
- COMETRIQ CAP 140MG DAILY DOSE PACK (New Starts Only)
- COMETRIQ CAP 60MG DAILY DOSE PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- COPIKTRA 15MG CAP (New Starts Only)
- COPIKTRA 25MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- CORLANOR 5MG TAB
- CORLANOR 7.5MG TAB
- CORLANOR 5MG/5ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For adults (18 years and older), one of the following: A) Member is on a maximally tolerated dose of beta blocker OR B) Member has a history of intolerance, contraindication, or a hypersensitivity to beta blocker.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a cardiologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- COTELLIC 20MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For unresectable or metastatic melanoma: Documentation is provided of appropriate BRAF V600E or V600K mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– CYSTARAN 0.44% OPHTH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- DAURISMO 100MG TAB (New Starts Only)
- DAURISMO 25MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- DIACOMIT 250MG CAP (New Starts Only)
- DIACOMIT 500MG CAP (New Starts Only)
- DIACOMIT 250MG POWDER FOR ORAL SUSP (New Starts Only)
- DIACOMIT 500MG POWDER FOR ORAL SUSP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of at least one anti-epileptic medication was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- DIFICID 200MG TAB
- DIFICID 40MG/ML SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of oral vancomycin was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month.
Other Criteria	

Products Affected

– DOJOLVI 100% ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Diagnosis of a long-chain fatty acid oxidation disorder confirmed by two or more of the following: a) newborn blood screening/acylcarnitine profile b) molecular or genetic test OR c) fibroblast test. For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a medical geneticist or prescriber specializing in the treatment of long-chain fatty acid oxidation disorders.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- DOPTELET 20MG TAB
- DOPTELET TAB 40MG DAILY DOSE PACK
- DOPTELET TAB 60MG DAILY DOSE PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For thrombocytopenia with chronic liver disease and scheduled to undergo a procedure: Member has a platelet count from the prior two weeks that shows less than 50,000 platelets per microliter. For chronic immune thrombocytopenia initial requests: Both of the following: A) Relapsed or refractory to at least one prior treatment for chronic immune thrombocytopenia B) Platelet count less than 30,000 microliters. For chronic immune thrombocytopenia continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For chronic immune thrombocytopenia: Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *dronabinol 10mg cap*
- *dronabinol 2.5mg cap*
- *dronabinol 5mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- DUPIXENT 100MG/0.67ML SYRINGE
- DUPIXENT 200MG/1.14ML SYRINGE
- DUPIXENT 300MG/2ML SYRINGE
- DUPIXENT 200MG/1.14ML AUTO-INJECTOR
- DUPIXENT 300MG/2ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: For atopic dermatitis: Two of the following were ineffective or not tolerated: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant (trial of other agents not required for patients under 2 years of age). For asthma: History, within the last year of at least 1 asthma exacerbation requiring one of the following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For nasal polyps: Both of the following were ineffective or not tolerated: a) an oral corticosteroid AND b) a nasal corticosteroid. For eosinophilic esophagitis: Trial of topical corticosteroid was ineffective or not tolerated. For prurigo nodularis: Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. For asthma: Prescribed by, or in consultation with, an allergist, pulmonologist, or immunologist. For nasal polyps: Prescribed by, or in consultation with, an allergist, immunologist, or otolaryngologist. For eosinophilic esophagitis: Prescribed by, or in consultation with, an allergist or gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For initial requests: For atopic dermatitis: Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For asthma: One of the following: 1) Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 150 cells/microliter) OR 2) Oral corticosteroid-dependent asthma requiring daily doses of 5 mg or greater prednisone (or equivalent). For nasal polyps, both of the following: A) Bilateral nasal polyposis confirmed with sinus CT scan AND B) Prescriber attests to moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). For eosinophilic esophagitis, both of the following: A) endoscopic biopsy with at least 15

	eosinophils per high-power field (hpf) AND B) symptoms of esophageal dysfunction (e.g. dysphagia). For prurigo nodularis: Both of the following apply: a) diagnosis has persisted for at least 6 weeks, AND b) at least 20 nodules present at baseline. For all indications (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

Products Affected

- EMGALITY 100MG/ML SYRINGE
- EMGALITY 120MG/ML SYRINGE
- EMGALITY 120MG/ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For migraine initial requests: Both of the following: A) Member has 4 or more migraine days per month for the previous 3 months or longer AND B) An 8-week or greater trial of two of the three following drug classes was ineffective or not tolerated: a) anticonvulsants, b) vasoactive agents, OR c) antidepressants. For episodic cluster headache prophylaxis initial requests: Trial of verapamil was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ENBREL 25MG/0.5ML INJ
- ENBREL 25MG/0.5ML SYRINGE
- ENBREL 50MG/ML AUTO-INJECTOR
- ENBREL 50MG/ML CARTRIDGE
- ENBREL 50MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): Trial of methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For ankylosing spondylitis (AS)(initial requests): Trial of sulfasalazine was ineffective or not tolerated (Trial of sulfasalazine not required for AS with predominant axial involvement). For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For juvenile psoriatic arthritis: Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, psoriatic arthritis, juvenile psoriatic arthritis, juvenile idiopathic arthritis or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ENDARI 5GM POWDER FOR ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Criteria 1 and 2 must be met or criteria 3 must be met: 1. Trial of a maximally tolerated hydroxyurea dose was ineffective or not tolerated. 2. Member has had at least 1 vaso-occlusive crisis in the prior 12 months, while on hydroxyurea (if applicable). 3. Prescriber is a hematologist. For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ENSPRYNG 120MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of a positive test for anti-aquaporin-4 antibodies.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, ophthalmologist, or neuro-ophthalmologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For all requests: Will not be used in combination with eculizumab (Soliris) or inebilizumab (Uplizna).

Products Affected

– SOFOSBUVIR/VELPATASVIR 400-100MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Current HCV-RNA titer is provided 2) No prior treatment with a direct-acting antiviral for hepatitis C. 3) One of the following: a) Member does not have cirrhosis OR b) Member has compensated cirrhosis AND one of the following: i) Does not have genotype 3 OR ii) has genotype 3 but no NS5A resistance-associated substitution Y93H. OR c) Member has decompensated cirrhosis AND will receive weight-based ribavirin
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a gastroenterologist, hepatologist, or infectious disease or transplant specialist.
Coverage Duration	Coverage duration of 12 to 24 weeks. Applied consistent with current AASLD-IDSA guidance.
Other Criteria	

Products Affected

– EPIDIOLEX 100MG/ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of at least one anti-epileptic medication was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ERIVEDGE 150MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ERLEADA 240MG TAB (New Starts Only)
- ERLEADA 60MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic castration-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated. For nonmetastatic castration-resistant prostate cancer: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *pirfenidone 267mg cap*
- *pirfenidone 267mg tab*
- *pirfenidone 801mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For idiopathic pulmonary fibrosis initial requests: Diagnosis confirmed by one of the following: 1) Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) 2) High-resolution computed tomography indicates definite UIP pattern 3) Both High-resolution computed tomography indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP. For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– EVRYSDI 0.75MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of a genetic test confirming diagnosis of spinal muscular atrophy.
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For all requests: Will not be used in combination with nusinersen (Spinraza).

Products Affected

- FANAPT 10MG TAB (New Starts Only)
- FANAPT 12MG TAB (New Starts Only)
- FANAPT 1MG TAB (New Starts Only)
- FANAPT 2MG TAB (New Starts Only)
- FANAPT 4MG TAB (New Starts Only)
- FANAPT 6MG TAB (New Starts Only)
- FANAPT 8MG TAB (New Starts Only)
- FANAPT TITRATION PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, OR f) lurasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- FASENRA 10MG/0.5ML SYRINGE
- FASENRA 30MG/ML AUTO-INJECTOR
- FASENRA 30MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: History within the last year of at least 1 asthma exacerbation requiring one of following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For asthma: Prescribed by, or in consultation with, an allergist, immunologist, or pulmonologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For asthma (initial requests): Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 150 cells/microliter. For asthma (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

Products Affected

- *deferiprone 1000mg tab*
- *deferiprone 500mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- FILSPARI 200MG TAB
- FILSPARI 400MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: 1) Diagnosis confirmed with a kidney biopsy and 2) Member unable to adequately control proteinuria with ACE inhibitor or angiotensin receptor blocker therapy alone. For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– FINTEPLA 2.2MG/ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of at least one anti-epileptic medication was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– FIRDAPSE 10MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	Diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) confirmed by one of the following: a) Presence of voltage-gated calcium channel antibodies OR b) electrophysiologic compound muscle action potential test findings are consistent with LEMS.

Products Affected

- FIRMAGON 120MG/VIAL INJ (New Starts Only)
- FIRMAGON 80MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- DICLOFENAC EPOLAMINE 1.3% PATCH
- FLECTOR 1.3% PATCH

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- FOTIVDA 0.89MG CAP (New Starts Only)
- FOTIVDA 1.34MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- FRUZAQLA 1MG CAP (New Starts Only)
- FRUZAQLA 5MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- FYCOMPA 0.5MG/ML SUSP (New Starts Only)
- FYCOMPA 10MG TAB (New Starts Only)
- FYCOMPA 12MG TAB (New Starts Only)
- FYCOMPA 2MG TAB (New Starts Only)
- FYCOMPA 4MG TAB (New Starts Only)
- FYCOMPA 6MG TAB (New Starts Only)
- FYCOMPA 8MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For partial-onset seizures: Both of the following were ineffective or not tolerated: a) topiramate AND b) lacosamide. For primary generalized tonic-clonic seizures: Two of the following were ineffective or not tolerated: a) lamotrigine, b) levetiracetam, c) primidone OR d) topiramate.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or epilepsy specialist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- GALAFOLD 123MG 28 DAY PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided that member has an amenable galactosidase alpha gene (GLA) variant.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a medical geneticist, nephrologist or a prescriber specialized in the treatment of Fabry disease.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– GATTEX 5MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is dependent on parenteral support for at least 12 months and at least 3 days per week.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– GAVRETO 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of RET gene fusion.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– GEMTESA 75MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Both of the following were ineffective or not tolerated: a) Myrbetriq AND b) one antimuscarinic agent.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- GILOTRIF 20MG TAB (New Starts Only)
- GILOTRIF 30MG TAB (New Starts Only)
- GILOTRIF 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate EGFR mutation. For squamous non-small cell lung cancer: Documentation of EGFR mutation not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- SKYTROFA 11MG CARTRIDGE
- SKYTROFA 13.3MG CARTRIDGE
- SKYTROFA 3.6MG CARTRIDGE
- SKYTROFA 3MG CARTRIDGE
- SKYTROFA 4.3MG CARTRIDGE
- SKYTROFA 5.2MG CARTRIDGE
- SKYTROFA 6.3MG CARTRIDGE
- SKYTROFA 7.6MG CARTRIDGE
- SKYTROFA 9.1MG CARTRIDGE
- SOGROYA 10MG/1.5ML PEN INJ
- SOGROYA 15MG/1.5ML PEN INJ
- SOGROYA 5MG/1.5ML PEN INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of failure to stimulate growth hormone secretion (peak growth hormone level of 10mcg/L or less) by one of the acceptable provocative tests.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- NORDITROPIN 10MG/1.5ML PEN INJ
- NORDITROPIN 15MG/1.5ML PEN INJ
- NORDITROPIN 30MG/3ML PEN INJ
- NORDITROPIN 5MG/1.5ML PEN INJ
- OMNITROPE 10MG/1.5ML CARTRIDGE
- OMNITROPE 5.8MG INJ
- OMNITROPE 5MG/1.5ML CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of failure to stimulate growth hormone secretion (peak growth hormone level of 10mcg/L or less) by one of the acceptable provocative tests.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- HADLIMA 40MG/0.4ML AUTO-INJECTOR
- HADLIMA 40MG/0.8ML AUTO-INJECTOR
- HADLIMA 40MG/0.4ML SYRINGE
- HADLIMA 40MG/0.8ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin. For ankylosing spondylitis (AS)(initial requests): Trial of sulfasalazine was ineffective or not tolerated (Trial of sulfasalazine not required for AS with predominant axial involvement). For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For ulcerative colitis or Crohn's disease (all requests): Trial of other agents not required. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) At least 3 cysts AND b) Trial of one oral antibiotic was ineffective or not tolerated. For uveitis (initial requests): Both of the following were ineffective or not tolerated: a) a corticosteroid AND b) an immunosuppressant (methotrexate or cyclosporine). For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, psoriatic arthritis, juvenile idiopathic arthritis or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis and hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For uveitis: Prescribed by, or in consult with, a rheumatology specialist OR ophthalmologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- BERINERT 500UNIT INJ
- HAEGARDA 2000UNIT INJ
- *icatibant 10mg/ml syringe*
- ORLADEYO 150MG CAP
- *sajazir 30mg/3ml syringe*
- TAKHZYRO 300MG/2ML SYRINGE
- CINRYZE 500UNIT INJ
- HAEGARDA 3000UNIT INJ
- ORLADEYO 110MG CAP
- RUCONEST 2100UNIT INJ
- TAKHZYRO 300MG/2ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *tasimelteon 20mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For non-24-hour sleep-wake disorder: Member is totally blind. For Smith-Magenis syndrome: Diagnosis of nighttime sleep disturbances in Smith-Magenis syndrome.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or sleep specialist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- HUMIRA 10MG/0.1ML SYRINGE (ABBVIE)
- HUMIRA 20MG/0.2ML SYRINGE (ABBVIE)
- HUMIRA 40MG/0.4ML AUTO-INJECTOR (ABBVIE)
- HUMIRA 40MG/0.4ML SYRINGE (ABBVIE)
- HUMIRA 40MG/0.8ML AUTO-INJECTOR
- HUMIRA 40MG/0.8ML SYRINGE
- HUMIRA 80MG/0.8ML AUTO-INJECTOR (ABBVIE)
- HUMIRA PEN - PEDIATRIC UC STARTER PACK 80MG/0.8ML INJ (A
- HUMIRA PEN 80MG/0.8ML AND 40MG/0.4ML - PSORIASIS/UVEITI
- HUMIRA PEN 80MG/0.8ML CROHNS/UC/HIDRADENITIS STARTER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin. For ankylosing spondylitis (AS)(initial requests): Trial of sulfasalazine was ineffective or not tolerated (Trial of sulfasalazine not required for AS with predominant axial involvement). For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For ulcerative colitis or Crohn's disease (all requests): Trial of other agents not required. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) At least 3 cysts AND b) Trial of one oral antibiotic was ineffective or not tolerated. For uveitis (initial requests): Both of the following were ineffective or not tolerated: a) a corticosteroid AND b) an immunosuppressant (methotrexate or cyclosporine). For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, psoriatic arthritis, juvenile idiopathic arthritis or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis and hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For uveitis: Prescribed by, or in consult with, a rheumatology specialist OR ophthalmologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- IBRANCE 100MG CAP (New Starts Only)
- IBRANCE 125MG CAP (New Starts Only)
- IBRANCE 75MG CAP (New Starts Only)
- IBRANCE 100MG TAB (New Starts Only)
- IBRANCE 125MG TAB (New Starts Only)
- IBRANCE 75MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance or contraindication to therapy with both of the following: a) Verzenio AND b) Kisqali.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ICLUSIG 10MG TAB (New Starts Only)
- ICLUSIG 15MG TAB (New Starts Only)
- ICLUSIG 30MG TAB (New Starts Only)
- ICLUSIG 45MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of IDH2 mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- IMBRUVICA 140MG CAP (New Starts Only)
- IMBRUVICA 420MG TAB (New Starts Only)
- IMBRUVICA 70MG CAP (New Starts Only)
- IMBRUVICA 70MG/ML SUSP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– INCRELEX 40MG/4ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- INGREZZA 40MG CAP
- INGREZZA 60MG CAP
- INGREZZA 80MG CAP
- INGREZZA CAP PACK
- INGREZZA 40MG SPRINKLE CAP
- INGREZZA 60MG SPRINKLE CAP
- INGREZZA 80MG SPRINKLE CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For tardive dyskinesia (initial requests): A) One of the following: i) Member has failed to respond to a change in current antidopaminergic therapy OR ii) Member is unable to switch current antidopaminergic therapy OR iii) Member has symptoms of tardive dyskinesia and is not using antidopaminergic therapy AND B) Member has a functional disability due to tardive dyskinesia. For chorea associated with Huntington's disease (initial requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or psychiatrist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- INLYTA 1MG TAB (New Starts Only)
- INLYTA 5MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– INQOVI 5 TABLET PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– INREBIC 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of Jakafi was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *gefitinib 250mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate EGFR mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *ivermectin 3mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month.
Other Criteria	

Products Affected

- BIVIGAM 5GM/50ML INJ
- GAMMAGARD 2.5GM/25ML INJ
- GAMMAKED 1GM/10ML INJ
- GAMMAPLEX 10GM/200ML INJ
- GAMMAPLEX 5GM/50ML INJ
- OCTAGAM 1GM/20ML INJ
- PANZYGA 10GM/100ML INJ
- PANZYGA 2.5GM/25ML INJ
- PANZYGA 30GM/300ML INJ
- PRIVIGEN 20GM/200ML INJ
- GAMMAGARD 10GM INJ
- GAMMAGARD 5GM INJ
- GAMMAPLEX 10GM/100ML INJ
- GAMMAPLEX 20GM/200ML INJ
- GAMUNEX 1GM/10ML INJ
- OCTAGAM 2GM/20ML INJ
- PANZYGA 1GM/10ML INJ
- PANZYGA 20GM/200ML INJ
- PANZYGA 5GM/50ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- IWILFIN 192MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- JAKAFI 10MG TAB (New Starts Only)
- JAKAFI 15MG TAB (New Starts Only)
- JAKAFI 20MG TAB (New Starts Only)
- JAKAFI 25MG TAB (New Starts Only)
- JAKAFI 5MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– JYLAMVO 2MG/ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is unable to swallow solid dosage forms of methotrexate.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- KALYDECO 13.4MG GRANULES
- KALYDECO 25MG GRANULES
- KALYDECO 50MG GRANULES
- KALYDECO 150MG TAB
- KALYDECO 5.8MG GRANULES
- KALYDECO 75MG GRANULES

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- KERENDIA 10MG TAB
- KERENDIA 20MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Rinvoq OR d) Xeljanz. For polymyalgia rheumatica (initial requests), one of the following: a) a trial of a corticosteroid was ineffective OR b) member was unable to tolerate a corticosteroid taper to less than or equal to 5 mg prednisone equivalent per day. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis and polymyalgia rheumatica: Prescribed by, or in consultation with, a rheumatology specialist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- KISQALI 200MG DAILY DOSE PACK (21) (New Starts Only)
- KISQALI 400MG DAILY DOSE PACK (42) (New Starts Only)
- KISQALI 600MG DAILY DOSE PACK (63) (New Starts Only)
- KISQALI/FEMARA 200 CO-PACK (New Starts Only)
- KISQALI/FEMARA 400 CO-PACK (New Starts Only)
- KISQALI/FEMARA 600 CO-PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- KORLYM 300MG TAB
- *mifepristone 300mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- KOSELUGO 10MG CAP (New Starts Only)
- KOSELUGO 25MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Chart notes documentation is provided that indicates inoperable and symptomatic disease
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- KRAZATI 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of KRAS G12C mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *javygtor 100mg powder for oral soln*
- *javygtor 500mg powder for oral soln*
- *sapropterin 100mg tab*
- *javygtor 100mg tab*
- *sapropterin 100mg powder for oral soln*
- *sapropterin 500mg powder for oral soln*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuation therapy: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a medical geneticist or metabolic physician.
Coverage Duration	Initial approval of 3 months. Continuing therapy approved for 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *ambrisentan 10mg tab*
- *ambrisentan 5mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- LIBERVANT 10MG BUCCAL FILM (New Starts Only)
- LIBERVANT 12.5MG BUCCAL FILM (New Starts Only)
- LIBERVANT 15MG BUCCAL FILM (New Starts Only)
- LIBERVANT 5MG BUCCAL FILM (New Starts Only)
- LIBERVANT 7.5MG BUCCAL FILM (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *lidocaine 5% patch*
- *lidocan 5% patch*

PA Criteria	Criteria Details
Covered Uses	All Medically-accepted Indications.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *lidocaine 5% ointment*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- LINZESS 145MCG CAP
- LINZESS 290MCG CAP
- LINZESS 72MCG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For irritable bowel syndrome with constiptation and chronic idiopathic constipation: Both of the following were ineffective or not tolerated: A) Trulance AND B) lubiprostone. Trial of lubiprostone not required for adult male patients with irritable bowel syndrome with constipation. For functional constipation in patients aged 6 to 17 years: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– LITFULO 50MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For alopecia areata (all requests): Trial of other agents not required. For alopecia areata (continuation requests): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– LIVTENCITY 200MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Prescriber attests that the medication will not be used for CMV infection prophylaxis.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist, oncologist, transplant or infectious disease specialist.
Coverage Duration	Approved for 3 months.
Other Criteria	

Products Affected

- LOKELMA 10GM POWDER FOR ORAL SUSP
- LOKELMA 5GM POWDER FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Member has baseline persistent potassium level greater than 5.0 mmol/L. For continuing requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist, cardiologist, hematologist or endocrinologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- LONSURF 6.14-15MG TAB (New Starts Only)
- LONSURF 8.19-20MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- LORBRENA 100MG TAB (New Starts Only)
- LORBRENA 25MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of ALK-positive disease.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– LUCEMYRA 0.18MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of clonidine was ineffective or not tolerated
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a prescriber specializing in pain management or addiction treatment.
Coverage Duration	Approved for 1 month.
Other Criteria	If member was initiated on lofexidine at an inpatient facility and request is for continuing therapy for up to a total of 14 days, prescriber and medical restrictions not required.

Products Affected

- LUMAKRAS 120MG TAB (New Starts Only)
- LUMAKRAS 320MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of KRAS G12C mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- LUMRYZ 4.5GM GRANULES FOR ORAL SUSP
- LUMRYZ 6GM GRANULES FOR ORAL SUSP
- LUMRYZ 7.5GM GRANULES FOR ORAL SUSP
- LUMRYZ 9GM GRANULES FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy in adults: Both of the following were ineffective or not tolerated: a) Sunosi AND b) either modafinil or armodafinil. For cataplexy with narcolepsy: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For excessive daytime sleepiness with narcolepsy: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy with narcolepsy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

Products Affected

– LUPKYNIS 7.9MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuation therapy: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatology specialist or nephrologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For all requests: Will not be used in combination with belimumab (Benlysta).

Products Affected

- LYNPARZA 100MG TAB (New Starts Only)
- LYNPARZA 150MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- LYTGOBI 4MG TAB PACK (12MG DAILY DOSE) (New Starts Only)
- LYTGOBI 4MG TAB PACK (16MG DAILY DOSE) (New Starts Only)
- LYTGOBI 4MG TAB PACK (20MG DAILY DOSE) (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of FGFR2 fusion or other rearrangement
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- MAVYRET 100-40MG TAB
- MAVYRET 50-20MG ORAL PELLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Current HCV-RNA titer is provided 2) Member does not have decompensated cirrhosis 3) One of the following: a) no prior treatment with a direct-acting antiviral for hepatitis C, OR b) prior treatment with sofosbuvir-based regimen and all of the following: i) Member does not have genotype 3 AND ii) No prior treatment with an NS3/4A protease inhibitor.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a gastroenterologist, hepatologist, or infectious disease or transplant specialist.
Coverage Duration	Coverage duration of 8 to 16 weeks. Applied consistent with current AASLD-IDSA guidance.
Other Criteria	

Products Affected

- MEGESTROL ACETATE 125MG/ML SUSP
- *megestrol acetate 40mg/ml susp*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *megestrol acetate 20mg tab (New Starts Only)*
- *megestrol acetate 40mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- MEKINIST 0.05MG/ML ORAL SOLN (New Starts Only)
- MEKINIST 0.5MG TAB (New Starts Only)
- MEKINIST 2MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate BRAF V600E or V600K mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– MEKTOVI 15MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate BRAF V600E or V600K mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *dihydroergotamine mesylate 0.5mg/act nasal inhaler*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of two different triptans was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- MOTEGRITY 1MG TAB
- MOTEGRITY 2MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of Trulance was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- MOUNJARO 10MG/0.5ML AUTO-INJECTOR
- MOUNJARO 12.5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 15MG/0.5ML AUTO-INJECTOR
- MOUNJARO 2.5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 7.5MG/0.5ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- MOVANTIK 12.5MG TAB
- MOVANTIK 25MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ABELCET 5MG/ML INJ
- *acetylcysteine 200mg/ml inh soln*
- *albuterol 0.21mg/ml (0.63mg/3ml) inh soln*
- *albuterol 1.25mg/3ml neb soln*
- AMPHOTERICIN B 50MG INJ
- *aprepitant 125mg/aprepitant 80mg cap therapy pack*
- *aprepitant 80mg cap*
- *azathioprine 50mg tab*
- *budesonide 0.25mg/ml inh susp*
- CLINIMIX 4.25/10 INJ
- CLINIMIX 5/15 INJ
- CLINIMIX E 2.75/5 INJ
- CLINIMIX E 4.25/5 INJ
- CLINIMIX E 5/20 INJ
- CYCLOPHOSPHAMIDE 25MG TAB
- *cyclosporine 100mg cap*
- *cyclosporine modified 100mg cap*
- *cyclosporine modified 25mg cap*
- DIPHTHERIA/TETANUS TOXOID INJ
- ENGERIX-B 20MCG/ML INJ
- ENVARSUS XR 0.75MG TAB
- ENVARSUS XR 4MG TAB
- *everolimus 0.5mg tab*
- *everolimus 1mg tab*
- *formoterol fumarate 20mcg/2ml neb soln*
- *gengraf 100mg/ml oral soln*
- *glucose 100mg/ml inj*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 4.5MG/ML INJ
- HEPLISAV-B 20MCG/0.5ML SYRINGE
- *acetylcysteine 100mg/ml inh soln*
- *acyclovir 50mg/ml inj*
- *albuterol 0.83mg/ml (0.083%) inh soln*
- *albuterol 5mg/ml inh soln*
- *aprepitant 125mg cap*
- *aprepitant 40mg cap*
- *arformoterol tartrate 15mcg/2ml neb soln*
- *budesonide 0.125mg/ml inh susp*
- *budesonide 0.5mg/ml inh susp*
- CLINIMIX 4.25/5 INJ
- CLINIMIX 5/20 INJ
- CLINIMIX E 4.25/10 INJ
- CLINIMIX E 5/15 INJ
- *clinisol 15 inj*
- CYCLOPHOSPHAMIDE 50MG TAB
- *cyclosporine 25mg cap*
- *cyclosporine modified 100mg/ml oral soln*
- *cyclosporine modified 50mg cap*
- ENGERIX-B 10MCG/0.5ML SYRINGE
- ENGERIX-B 20MCG/ML SYRINGE
- ENVARSUS XR 1MG TAB
- *everolimus 0.25mg tab*
- *everolimus 0.75mg tab*
- FIASP 100UNIT/ML INJ
- *gengraf 100mg cap*
- *gengraf 25mg cap*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 2MG/ML INJ
- *granisetron 1mg tab*
- HUMULIN R 500UNIT/ML INJ

- IMOVAX 2.5UNIT/ML INJ
- INSULIN LISPRO 100UNIT/ML INJ
- INTRALIPID 30GM/100ML INJ
- *ipratropium/albuterol 0.5-2.5mg/3ml inh soln*
- *levalbuterol 0.63mg/3ml inh soln*
- *levalbuterol 1.25mg/3ml neb soln*
- *methylprednisolone 16mg tab*
- *methylprednisolone 4mg tab*
- *mycophenolate mofetil 200mg/ml susp*
- *mycophenolate mofetil 500mg tab*
- *mycophenolic acid 360mg dr tab*
- NUTRILIPID 20GM/100ML INJ
- *ondansetron 4mg odt*
- *ondansetron 8mg odt*
- *pentamidine isethionate 50mg/ml inh soln*
- *prednisolone 1mg/ml oral soln*
- *prednisolone 4mg/ml oral soln*
- *prednisone 10mg tab*
- PREDNISONE 1MG/ML ORAL SOLN
- *prednisone 20mg tab*
- *prednisone 5mg tab*
- PREMASOL 10% INJ
- PROGRAF 1MG GRANULES FOR ORAL SUSP
- PULMOZYME 1MG/ML INH SOLN
- RECOMBIVAX 10MCG/ML INJ
- RECOMBIVAX 40MCG/ML INJ
- RECOMBIVAX 5MCG/0.5ML SYRINGE
- *sirolimus 0.5mg tab*
- *sirolimus 1mg/ml oral soln*
- *tacrolimus 0.5mg cap*
- INSULIN ASPART HUMAN 100UNIT/ML INJ
- INTRALIPID 20GM/100ML INJ
- *ipratropium bromide 0.02% inh soln*
- *levalbuterol 0.31mg/3ml neb soln*
- *levalbuterol 1.25mg/0.5ml neb soln*
- LYUMJEV 100UNIT/ML INJ
- *methylprednisolone 32mg tab*
- *methylprednisolone 8mg tab*
- *mycophenolate mofetil 250mg cap*
- *mycophenolic acid 180mg dr tab*
- NOVOLOG 100UNIT/ML INJ
- *ondansetron 0.8mg/ml oral soln*
- *ondansetron 4mg tab*
- *ondansetron 8mg tab*
- *plenamine 15% inj*
- *prednisolone 3mg/ml oral soln*
- *prednisolone 5mg/ml oral soln*
- *prednisone 1mg tab*
- *prednisone 2.5mg tab*
- *prednisone 50mg tab*
- PREHEVBRIO 10MCG/ML INJ
- PROGRAF 0.2MG GRANULES FOR ORAL SUSP
- PROSOL 20% INJ
- RABAVERT 2.5UNIT/ML INJ
- RECOMBIVAX 10MCG/ML SYRINGE
- RECOMBIVAX 5MCG/0.5ML INJ
- SANDIMMUNE 100MG/ML ORAL SOLN
- *sirolimus 1mg tab*
- *sirolimus 2mg tab*
- *tacrolimus 1mg cap*

- *tacrolimus 5mg cap*
- TENIVAC 4-10UNIT/ML INJ
- TPN ELECTROLYTES INJ
- TROPHAMINE 10% INJ
- TDVAX 4-4UNIT/ML INJ
- TENIVAC 4-10UNIT/ML SYRINGE
- TRAVASOL 10% INJ
- VARUBI 90MG TAB

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

Products Affected

– NERLYNX 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *sorafenib 200mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- NEXLETOL 180MG TAB
- NEXLIZET 180-10MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- NINLARO 2.3MG CAP (New Starts Only)
- NINLARO 3MG CAP (New Starts Only)
- NINLARO 4MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *droxidopa 100mg cap*
- *droxidopa 200mg cap*
- *droxidopa 300mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- NOURIANZ 20MG TAB
- NOURIANZ 40MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	One agent from both of the following classes was ineffective or not tolerated: a) COMT inhibitor AND b) MAO-B inhibitor.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- NOXAFIL 300MG POWDER FOR ORAL SUSP
- *posaconazole 40mg/ml susp*
- *posaconazole 100mg dr tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– NUBEQA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic hormone-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated. For non-metastatic castration-resistant prostate cancer: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- NUCALA 100MG INJ
- NUCALA 100MG/ML AUTO-INJECTOR
- NUCALA 100MG/ML SYRINGE
- NUCALA 40MG/0.4ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For asthma initial requests: History within the last year of at least 1 asthma exacerbation requiring one of the following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For eosinophilic granulomatosis with polyangiitis (EGPA) initial requests: All of the following: A) One of the following: 1) baseline blood eosinophil count greater than 1000 cells per microliter OR 2) baseline blood eosinophil count greater than 10% of the total leukocyte count B) Trial of oral corticosteroid therapy was ineffective or not tolerated C) One of the following was ineffective or not tolerated: a) cyclophosphamide OR b) methotrexate. For hypereosinophilic syndrome (HES) initial requests: Both of the following: A) Diagnosis confirmed by blood eosinophil count greater than 1000 cells per microliter AND B) Hypereosinophilic syndrome has persisted for at least six months. For nasal polyps initial requests: Both of the following were ineffective or not tolerated: a) an oral corticosteroid AND b) a nasal corticosteroid. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with: For asthma: an allergist, pulmonologist, or immunologist. For nasal polyps: an allergist, immunologist, or otolaryngologist. For EGPA: a rheumatology specialist, allergist, pulmonologist, or immunologist. For HES: a rheumatology specialist, allergist, pulmonologist, gastroenterologist, hematologist, or other specialist experienced in the diagnosis and treatment of HES
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For asthma (initial requests): Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 150 cells/microliter. For asthma (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

Products Affected

– NUEDEXTA 20-10MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: A) Documentation is provided (in the form of chart notes or imaging) of structural neurological condition as the cause of pseudobulbar affect. For continuation requests, both of the following: A) Documentation is provided (in the form of chart notes or imaging) of structural neurological condition as the cause of pseudobulbar affect AND B) Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- NUPLAZID 10MG TAB (New Starts Only)
- NUPLAZID 34MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *armodafinil 150mg tab*
- *armodafinil 200mg tab*
- *armodafinil 250mg tab*
- *armodafinil 50mg tab*
- *modafinil 100mg tab*
- *modafinil 200mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– NUZYRA 150MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month.
Other Criteria	

Products Affected

- OCALIVA 10MG TAB
- OCALIVA 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has one of the following: a) inadequate response to a year of therapy with ursodiol OR b) experienced intolerance to ursodiol.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hepatologist or gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *octreotide 0.05mg/ml inj*
- *octreotide 0.1mg/ml inj*
- *octreotide 0.2mg/ml inj*
- *octreotide 0.5mg/ml inj*
- *octreotide 1mg/ml inj*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ODOMZO 200MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- OFEV 100MG CAP
- OFEV 150MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) For idiopathic pulmonary fibrosis initial requests: A) Diagnosis confirmed by one of the following: i) Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) ii) High-resolution computed tomography (HRCT) indicates definite UIP pattern iii) Both HRCT indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP AND B) Trial of pirfenidone was ineffective or not tolerated. 2) For systemic sclerosis-associated interstitial lung disease (ILD) initial requests: A) Diagnosis confirmed with documentation provided of both of the following: i) HRCT scan AND ii) pulmonary function tests AND B) Trial of mycophenolate mofetil was ineffective or not tolerated. 3) For chronic fibrosing ILDs with a progressive phenotype initial requests: A) Disease is progressive, defined by one of the following over the past 12 months, with no alternative explanation: i) worsening respiratory symptoms, ii) one of the following: a) forced vital capacity (FVC) decline of 5% or more OR b) corrected hemoglobin decline of 10% or more OR iii) radiological evidence of disease progression AND B) Progression occurred despite treatment with one of the following: i) azathioprine ii) cyclosporine iii) mycophenolate mofetil iv) tacrolimus v) oral corticosteroids equivalent to 20 mg or more per day of prednisone vi) cyclophosphamide vii) rituximab. 4) For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- OGSIVEO 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- OJJAARA 100MG TAB (New Starts Only)
- OJJAARA 150MG TAB (New Starts Only)
- OJJAARA 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- OLUMIANT 1MG TAB
- OLUMIANT 2MG TAB
- OLUMIANT 4MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Rinvoq OR d) Xeljanz. For alopecia areata (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis: Prescribed by or in consultation with, a rheumatology specialist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– OPSUMIT 10MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *fentanyl 1200mcg lozenge*
- *fentanyl 1600mcg lozenge*
- *fentanyl 200mcg lozenge*
- *fentanyl 400mcg lozenge*
- *fentanyl 600mcg lozenge*
- *fentanyl 800mcg lozenge*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documented tolerance to opioids defined as patients taking around the clock medicine consisting of at least 60mg of oral morphine daily, at least 25mcg of transdermal fentanyl per hour, at least 30mg of oxycodone daily, at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid daily for a week or longer.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ORENCIA 125MG/ML AUTO-INJECTOR
- ORENCIA 125MG/ML SYRINGE
- ORENCIA 50MG/0.4ML SYRINGE
- ORENCIA 87.5MG/0.7ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Enbrel, b) Humira or Hadlima, c) Rinvoq OR d) Xeljanz. For polyarticular juvenile idiopathic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel OR c) Xeljanz. For adult psoriatic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Taltz, d) Stelara, e) Otezla, f) Skyrizi, g) Tremfya, h) Rinvoq OR i) Xeljanz. For pediatric psoriatic arthritis (initial requests): Trial of Enbrel was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, and psoriatic arthritis (adult and pediatric): Prescribed by, or in consultation with a rheumatology specialist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ORENITRAM 0.125MG ER TAB
- ORENITRAM 0.25MG ER TAB
- ORENITRAM 1MG ER TAB
- ORENITRAM 2.5MG ER TAB
- ORENITRAM 5MG ER TAB
- ORENITRAM ER TAB MONTH 1 TITRATION KIT PACK
- ORENITRAM ER TAB MONTH 2 TITRATION KIT PACK
- ORENITRAM ER TAB MONTH 3 TITRATION KIT PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *nitisinone 10mg cap*
- *nitisinone 2mg cap*
- ORFADIN 4MG/ML SUSP
- *nitisinone 20mg cap*
- *nitisinone 5mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ORGOVYX 120MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ORKAMBI 125-100MG GRANULES
- ORKAMBI 125-100MG TAB
- ORKAMBI 125-200MG TAB
- ORKAMBI 188-150MG GRANULES
- ORKAMBI 94-75MG GRANULES

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ORSERDU 345MG TAB (New Starts Only)
- ORSERDU 86MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of ESR1 mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- OSPHENA 60MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Both of the following were ineffective or not tolerated: a) generic estradiol vaginal cream and b) Premarin vaginal cream.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- OTEZLA 28-DAY STARTER PACK
- OTEZLA 30MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For oral ulcers associated with Behcet's disease (initial requests): Trial of topical triamcinolone 0.1% oral paste was ineffective or not tolerated. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For oral ulcers associated with Behcet's disease and psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For oral ulcers associated with Behcet's disease (initial requests): Diagnosis confirmed by the presence of oral ulcers AND at least two of the following: recurrent genital ulceration, eye lesions, skin lesions, positive pathergy test. For psoriatic arthritis and plaque psoriasis (all requests): Will not be used in combination with biologic therapy for the prescribed indication.

Products Affected

- OXBRYTA 300MG TAB
- OXBRYTA 300MG TAB FOR ORAL SUSP
- OXBRYTA 500MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Criteria 1 and 2 must be met or criteria 3 must be met: 1. Trial of a maximally tolerated hydroxyurea dose was ineffective or not tolerated. 2. Member has had at least 1 vaso-occlusive crisis in the prior 12 months, while on hydroxyurea (if applicable). 3. Prescriber is a hematologist. For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For all requests: Will not be used in combination with crizanlizumab (Adakveo).

Products Affected

– OXERVATE 0.002% OPHTH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Eye to be treated has never been treated with Oxervate in the past.
Age Restrictions	
Prescriber Restriction	Prescribed by an ophthalmologist.
Coverage Duration	Approved for 3 months.
Other Criteria	

Products Affected

- OZEMPIC 2.68MG/ML PEN INJ
- OZEMPIC 2MG/3ML PEN INJ
- OZEMPIC 4MG/3ML PEN INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- PALYNZIQ 10MG/0.5ML SYRINGE
- PALYNZIQ 2.5MG/0.5ML SYRINGE
- PALYNZIQ 20MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with, a medical geneticist or metabolic physician.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– PANRETIN 0.1% GEL (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- PEMAZYRE 13.5MG TAB (New Starts Only)
- PEMAZYRE 4.5MG TAB (New Starts Only)
- PEMAZYRE 9MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate FGFR fusion or rearrangement.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- PIQRAY 200MG DAILY DOSE PACK (New Starts Only)
- PIQRAY 250MG DAILY DOSE PACK (New Starts Only)
- PIQRAY 300MG DAILY DOSE PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of PIK3CA-mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- POMALYST 1MG CAP (New Starts Only)
- POMALYST 2MG CAP (New Starts Only)
- POMALYST 3MG CAP (New Starts Only)
- POMALYST 4MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- PRALUENT 150MG/ML AUTO-INJECTOR
- PRALUENT 75MG/ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of Repatha was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- PREVYMIS 240MG TAB
- PREVYMIS 480MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member will/has initiated Prevymis within 30 days after an allogeneic hematopoietic stem cell transplant or 7 days after kidney tranplant.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist, oncologist, transplant or infectious disease specialist.
Coverage Duration	Approved for 8 months for hematopoietic stem cell transplant or 8 months for kidney transplant.
Other Criteria	

Products Affected

- PROMACTA 12.5MG POWDER FOR ORAL SUSP
- PROMACTA 25MG POWDER FOR ORAL SUSP
- PROMACTA 50MG TAB
- PROMACTA 12.5MG TAB
- PROMACTA 25MG TAB
- PROMACTA 75MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- PYRUKYND 20MG TAB (4-WEEK PACK)
- PYRUKYND 50MG TAB (4-WEEK PACK)
- PYRUKYND 5MG TAB TAPER PACK
- PYRUKYND 20MG/50MG TAB TAPER PACK
- PYRUKYND 5MG TAB (4-WEEK PACK)
- PYRUKYND 5MG/20MG TAB TAPER PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Diagnosis of pyruvate kinase deficiency confirmed by genetic testing (documentation is provided). For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist or a specialist in treating pyruvate kinase deficiency.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– QINLOCK 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *quinine sulfate 324mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month.
Other Criteria	

Products Affected

- RADICAVA 105MG/5ML SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Member has a score of two or greater for each individual item on the Amyotrophic Lateral Sclerosis Functional Rating Scale-Revised (ALSFRS-R). For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– REGRANEX 0.01% GEL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the treatment of opioid-induced constipation (OIC) in adults with advanced illness who are receiving palliative care: Trial of lactulose was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 4 months.
Other Criteria	

Products Affected

- RELTONE 200MG CAP
- RELTONE 400MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of generic ursodiol 300 mg capsule was ineffective or not tolerated
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- REPATHA 140MG/ML AUTO-INJECTOR
- REPATHA 140MG/ML SYRINGE
- REPATHA 420MG/3.5ML CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- RETACRIT 10000UNIT/ML INJ
- RETACRIT 20000UNIT/ML INJ
- RETACRIT 3000UNIT/ML INJ
- RETACRIT 4000UNIT/ML INJ
- RETACRIT 20000UNIT/2ML INJ
- RETACRIT 2000UNIT/ML INJ
- RETACRIT 40000UNIT/ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- RETEVMO 40MG CAP (New Starts Only)
- RETEVMO 80MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of RET mutation or RET gene fusion.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *sildenafil 20mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *lenalidomide 10mg cap (New Starts Only)*
- *lenalidomide 15mg cap (New Starts Only)*
- *lenalidomide 2.5mg cap (New Starts Only)*
- *lenalidomide 20mg cap (New Starts Only)*
- *lenalidomide 25mg cap (New Starts Only)*
- *lenalidomide 5mg cap (New Starts Only)*
- REVLIMID 10MG CAP (New Starts Only)
- REVLIMID 15MG CAP (New Starts Only)
- REVLIMID 2.5MG CAP (New Starts Only)
- REVLIMID 20MG CAP (New Starts Only)
- REVLIMID 25MG CAP (New Starts Only)
- REVLIMID 5MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- REXULTI 0.25MG TAB (New Starts Only)
- REXULTI 0.5MG TAB (New Starts Only)
- REXULTI 1MG TAB (New Starts Only)
- REXULTI 2MG TAB (New Starts Only)
- REXULTI 3MG TAB (New Starts Only)
- REXULTI 4MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For schizophrenia: Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, OR f) lurasidone. For major depressive disorder: Trial of aripiprazole was ineffective or not tolerated. For agitation associated with dementia due to Alzheimer's disease: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- REYVOW 100MG TAB
- REYVOW 50MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of two different triptans was ineffective or not tolerated
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– REZLIDHIA 150MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of IDH1 mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– REZUROCK 200MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- RINVOQ 15MG ER TAB
- RINVOQ 30MG ER TAB
- RINVOQ 45MG ER TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For atopic dermatitis (initial requests): Two of the following were ineffective or not tolerated: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant. For ulcerative colitis (initial requests): Trial of Humira or Hadlima was ineffective or not tolerated. For ankylosing spondylitis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For non-radiographic axial spondyloarthritis (initial requests): Trial of Cimzia was ineffective or not tolerated. For Crohn's disease (initial requests): Trial of Humira or Hadlima was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, non-radiographic axial spondyloarthritis, or juvenile idiopathic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. For Crohn's disease or ulcerative colitis: Prescribed by, or in consultation with a gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For atopic dermatitis (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

Products Affected

- ROZLYTREK 100MG CAP (New Starts Only)
- ROZLYTREK 200MG CAP (New Starts Only)
- ROZLYTREK 50MG ORAL PELLET (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided showing one of the following: a) ROS1 rearrangement OR b) NTRK gene fusion mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- RUBRACA 200MG TAB (New Starts Only)
- RUBRACA 250MG TAB (New Starts Only)
- RUBRACA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- RYBELSUS 14MG TAB
- RYBELSUS 3MG TAB
- RYBELSUS 7MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– RYDAPT 25MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- SCEMBLIX 20MG TAB (New Starts Only)
- SCEMBLIX 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For T315I mutation: failure of or intolerance to Iclusig required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- SECUADO 3.8MG/24HR PATCH (New Starts Only)
- SECUADO 5.7MG/24HR PATCH (New Starts Only)
- SECUADO 7.6MG/24HR PATCH (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, f) lurasidone, OR g) oral asenapine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- SIGNIFOR 0.3MG/ML INJ
- SIGNIFOR 0.6MG/ML INJ
- SIGNIFOR 0.9MG/ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Rinvoq OR d) Xeljanz. For ankylosing spondylitis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Taltz d) Rinvoq OR e) Xeljanz. For psoriatic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Taltz, d) Stelara, e) Otezla, f) Skyrizi, g) Tremfya, h) Rinvoq, OR i) Xeljanz. For ulcerative colitis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Stelara, c) Rinvoq OR d) Xeljanz. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For ulcerative colitis : Prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- SIRTURO 100MG TAB
- SIRTURO 20MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- SIVEXTRO 200MG INJ
- SIVEXTRO 200MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 6 months.
Other Criteria	

Products Affected

- SKYRIZI 150MG/ML AUTO-INJECTOR
- SKYRIZI 150MG/ML SYRINGE
- SKYRIZI 180MG/1.2ML CARTRIDGE
- SKYRIZI 360MG/2.4ML CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For Crohn's disease (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist. For Psoriatic Arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's Disease: Prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *diclofenac sodium 3% gel*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- SPRITAM 1000MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 250MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 500MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 750MG TAB FOR ORAL SUSP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of generic levetiracetam was ineffective or not tolerated
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For ulcerative colitis and Crohn's disease (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– STIVARGA 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– SUCRAID 8500UNIT/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- SUNOSI 150MG TAB
- SUNOSI 75MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	One of the following was ineffective or not tolerated: a) modafinil OR b) armodafinil.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis.

Products Affected

- *sunitinib 12.5mg cap (New Starts Only)*
- *sunitinib 25mg cap (New Starts Only)*
- *sunitinib 37.5mg cap (New Starts Only)*
- *sunitinib 50mg cap (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- SYMDEKO 50-75MG/75MG PACK
- SYMDEKO TAB 4-WEEK PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– SYMPROIC 0.2MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– SYNAREL 2MG/ML NASAL INHALER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *trientine 250mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- TABRECTA 150MG TAB (New Starts Only)
- TABRECTA 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of MET exon 14 skipping mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- TAFINLAR 10MG TAB FOR ORAL SUSP (New Starts Only)
- TAFINLAR 50MG CAP (New Starts Only)
- TAFINLAR 75MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate BRAF V600E or V600K mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- TAGRISSO 40MG TAB (New Starts Only)
- TAGRISSO 80MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate EGFR mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- TALTZ 80MG/ML AUTO-INJECTOR
- TALTZ 80MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For ankylosing spondylitis (AS)(initial requests): Trial of sulfasalazine was ineffective or not tolerated (Trial of sulfasalazine not required for AS with predominant axial involvement). For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For non-radiographic axial spondyloarthritis (initial requests): Trial of two non-steroidal anti-inflammatory drugs (NSAIDs) was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For psoriatic arthritis, non-radiographic axial spondyloarthritis and ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- TALZENNA 0.1MG CAP (New Starts Only)
- TALZENNA 0.25MG CAP (New Starts Only)
- TALZENNA 0.35MG CAP (New Starts Only)
- TALZENNA 0.5MG CAP (New Starts Only)
- TALZENNA 0.75MG CAP (New Starts Only)
- TALZENNA 1MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *erlotinib 100mg tab (New Starts Only)*
- *erlotinib 150mg tab (New Starts Only)*
- *erlotinib 25mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate EGFR mutation. For pancreatic cancer: Documentation of EGFR mutation not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *bexarotene 1% gel (New Starts Only)*
- *bexarotene 75mg cap (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- TASIGNA 150MG CAP (New Starts Only)
- TASIGNA 200MG CAP (New Starts Only)
- TASIGNA 50MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– TAZVERIK 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– TEPMETKO 225MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of MET exon 14 skipping mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *testosterone 1% (12.5mg/act) gel pump*
- *testosterone 1% (25mg) gel packet*
- *testosterone 1% (50mg) gel packet*
- *testosterone 1.62% (1.25gm) gel packet*
- *testosterone 1.62% (2.5gm) gel packet*
- *testosterone 1.62% (20.25mg/act) gel pump*
- *testosterone 30mg/act topical soln*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) For initial requests: documentation is provided of morning testosterone levels, from two separate days, that fall below the normal range for a healthy adult male. B) For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– TIBSOVO 250MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of IDH1 mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *tobramycin 60mg/ml inh soln*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- *bosentan 125mg tab*
- *bosentan 62.5mg tab*
- TRACLEER 32MG TAB FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- TREMFYA 100MG/ML AUTO-INJECTOR
- TREMFYA 100MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis: Prescribed by, or in consultation, with a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- TRIKAFTA 100-50-75MG/150MG PACK
- TRIKAFTA 50-37.5-25MG/75MG TAB PACK
- TRIKAFTA 100-50-75MG/75MG GRANULES PACK
- TRIKAFTA 80-40-60MG/59.5MG GRANULES PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- TRULICITY 0.75MG/0.5ML AUTO-INJECTOR
- TRULICITY 1.5MG/0.5ML AUTO-INJECTOR
- TRULICITY 3MG/0.5ML AUTO-INJECTOR
- TRULICITY 4.5MG/0.5ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- TRUQAP 160MG TAB (New Starts Only)
- TRUQAP 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of PIK3CA, AKT1, or PTEN alteration.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– TURALIO 125MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- TYVASO 16-32-48MCG TITRATION PACK
- TYVASO 32-48MCG MAINTENANCE PACK
- TYVASO 48MCG INH POWDER
- TYVASO 16MCG INH POWDER
- TYVASO 32MCG INH POWDER
- TYVASO 64MCG INH POWDER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For all indications: Diagnosis confirmed by right heart catheterization. For pulmonary arterial hypertension associated with interstitial lung disease: Interstitial lung disease confirmed by high-resolution computed tomography (HRCT).
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- UBRELVY 100MG TAB
- UBRELVY 50MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of one triptan was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *budesonide 2mg/act rectal foam*
- *budesonide 9mg er tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of mesalamine was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– VALCHLOR 0.016% GEL (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- VANFLYTA 17.7MG TAB (New Starts Only)
- VANFLYTA 26.5MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of an FLT3 internal tandem duplication (ITD) mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- VELTASSA 16.8GM POWDER FOR ORAL SUSP
- VELTASSA 25.2GM POWDER FOR ORAL SUSP
- VELTASSA 8.4GM POWDER FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Member has baseline persistent potassium level greater than 5.0 mmol/L. For continuing requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist, cardiologist, hematologist or endocrinologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- VENCLEXTA 100MG TAB (New Starts Only)
- VENCLEXTA 10MG TAB (New Starts Only)
- VENCLEXTA 50MG TAB (New Starts Only)
- VENCLEXTA TAB STARTER PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- VERQUVO 10MG TAB
- VERQUVO 2.5MG TAB
- VERQUVO 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- VERZENIO 100MG TAB (New Starts Only)
- VERZENIO 150MG TAB (New Starts Only)
- VERZENIO 200MG TAB (New Starts Only)
- VERZENIO 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– VICTOZA 18MG/3ML PEN INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- VITRAKVI 100MG CAP (New Starts Only)
- VITRAKVI 25MG CAP (New Starts Only)
- VITRAKVI 20MG/ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of NTRK gene fusion mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- VIZIMPRO 15MG TAB (New Starts Only)
- VIZIMPRO 30MG TAB (New Starts Only)
- VIZIMPRO 45MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate EGFR mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– VONJO 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- VORICONAZOLE 200MG INJ
- *voriconazole 200mg tab*
- *voriconazole 40mg/ml susp*
- *voriconazole 50mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 6 months.
Other Criteria	

Products Affected

– VOSEVI 400-100-100MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Current HCV-RNA titer is provided 3) Member does not have decompensated cirrhosis 3) Previous Hepatitis C treatment(s) is provided.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a gastroenterologist, hepatologist, or infectious disease or transplant specialist.
Coverage Duration	Coverage duration of 12 weeks.
Other Criteria	Treatment regimen will be approved based on previous treatment experience as defined by current AASLD guidelines.

Products Affected

– *pazopanib 200mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– VOWST 30000000UNIT CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month.
Other Criteria	For all requests: Will not be used in combination with fecal microbiota, live for rectal use (Rebyota) or bezlotoxumab (Zinplava)

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, OR f) lurasidone. For major depressive disorder: Trial of aripiprazole was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- VYNDAMAX 61MG CAP
- VYNDAQEL 20MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Initial requests: Diagnosis confirmed by one of the following: A) Cardiac biopsy with positive congo red staining and ATTR confirmation by mass spectrometry or immunofluorescence staining OR B) All of the following: i) Serum kappa/lambda free light chain ratio 0.26 to 1.65 AND ii) Absence of monoclonal protein via serum protein immunofixation AND iii) Absence of monoclonal protein via urine protein immunofixation AND iv) Myocardial uptake of 99mTc-PYP demonstrated by a greater than 1.5 heart-to-contralateral ratio or grade 2 or greater visual evidence. For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a cardiologist or other provider experienced in the treatment of cardiomyopathy of transthyretin-mediated amyloidosis.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For all requests: Will not be used in combination with Tegsedi, Onpattro, or Amvuttra.

Products Affected

- WAKIX 17.8MG TAB
- WAKIX 4.45MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy: Both of the following were ineffective or not tolerated: a) Sunosi AND b) either modafinil or armodafinil. For cataplexy with narcolepsy: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For narcolepsy: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

Products Affected

– WELIREG 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- XALKORI 150MG ORAL PELLET (New Starts Only)
- XALKORI 20MG ORAL PELLET (New Starts Only)
- XALKORI 50MG ORAL PELLET (New Starts Only)
- XALKORI 200MG CAP (New Starts Only)
- XALKORI 250MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of ALK-positive or ROS1-positive disease.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– XATMEP 2.5MG/ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For polyarticular juvenile idiopathic arthritis: Member is unable to swallow solid dosage forms of methotrexate. For acute lymphoblastic leukemia: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– XDEMVY 0.25% OPHTH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an ophthalmologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For juvenile idiopathic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For ankylosing spondylitis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For ulcerative colitis (initial requests): Failure of, or intolerance to Humira or Hadlima. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, juvenile idiopathic arthritis, ankylosing spondylitis, or psoriatic arthritis: Prescribed by, or in consultation with a rheumatology specialist. For ulcerative colitis : Prescribed by, or in consultation with a gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– XERMELO 250MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- XGEVA 120MG/1.7ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– XIFAXAN 550MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For diagnosis of IBS-D, approval will increase quantity limit to 42 tablets over 14 days, maximum of three fills per 1 year.

Products Affected

- XOLAIR 150MG INJ
- XOLAIR 150MG/ML SYRINGE
- XOLAIR 300MG/2ML SYRINGE
- XOLAIR 75MG/0.5ML SYRINGE
- XOLAIR 150MG/ML AUTO-INJECTOR
- XOLAIR 300MG/2ML AUTO-INJECTOR
- XOLAIR 75MG/0.5ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: For asthma: History within the last year of at least 1 asthma exacerbation requiring one of the following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For chronic idiopathic urticaria: one of the following: a) patient remains symptomatic despite H1 antihistamine treatment OR b) has intolerance or contraindication to H1 antihistamine treatment. For nasal polyps: A) Confirmed diagnosis of nasal polyps (see other criteria) AND B) Trial of Dupixent was ineffective or not tolerated. For IgE-mediated food allergy: Confirmed diagnosis of IgE-mediated food allergy (see other criteria). For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For asthma: Prescribed by, or in consultation with an allergist, pulmonologist, or immunologist. For chronic idiopathic urticaria: Prescribed by, or in consultation with an allergist, dermatologist, or immunologist. For nasal polyps: Prescribed by, or in consultation with, an allergist, immunologist, or otolaryngologist. For IgE-mediated food allergy: Prescribed by, or in consultation with an allergist or immunologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For asthma (initial requests): Documentation of diagnosis via skin test or RAST for specific allergy sensitivity. For nasal polyps (initial requests): Diagnosis is confirmed with a sinus CT scan AND at least four of the following apply: a) prior surgery for bilateral nasal polyposis b) evidence of type 2 inflammation c) two or more courses of oral corticosteroids required in the prior year d) significantly impaired quality of life e) significant loss of smell f) diagnosis of comorbid asthma. For IgE-mediated food allergy (initial requests): Both of the following: a) diagnosis supported by one of the following: i) positive skin prick test or ii) positive serum IgE test and b) diagnosis confirmed by one of the following: i) positive oral food challenge or ii) history of anaphylaxis to the suspected food allergen. For asthma (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication. For IgE-mediated

	food allergy (all requests): Will not be used in combination with peanut allergen powder (Palforzia).

Products Affected

– XOSPATA 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of FLT3 mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- XPOVIO 100MG ONCE WEEKLY CARTON (8-PACK) (New Starts Onl
- XPOVIO 40MG TWICE WEEKLY CARTON (8-PACK) (New Starts Onl
- XPOVIO 60MG TWICE WEEKLY CARTON (24 PACK) (New Starts On
- XPOVIO 80MG TWICE WEEKLY CARTON (32 PACK) (New Starts On
- XPOVIO 40MG ONCE WEEKLY CARTON (4-PACK) (New Starts Only
- XPOVIO 60MG ONCE WEEKLY CARTON (4-PACK) (New Starts Only
- XPOVIO 80MG ONCE WEEKLY CARTON (8-PACK) (New Starts Only

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- XTANDI 40MG CAP (New Starts Only)
- XTANDI 40MG TAB (New Starts Only)
- XTANDI 80MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications, Some Medically-Accepted Indications
Exclusion Criteria	
Required Medical Info	For metastatic castration-resistant prostate cancer and metastatic castration-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated. For nonmetastatic castration-resistant prostate cancer: Both of the following were ineffective or not tolerated: a) Nubeqa and b) Erleada. For non metastatic castration sensitive prostate cancer with biochemical recurrence at high risk for metastasis: Trial of other agents not required. For homologous recombination repair gene-mutated metastatic castration-resistant prostate cancer in combination with Talzenna: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *miglustat 100mg cap*
- *yargesa 100mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ZAVZPRET 10MG/ACT NASAL SPRAY

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of one triptan was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ZEJULA 100MG CAP (New Starts Only)
- ZEJULA 100MG TAB (New Starts Only)
- ZEJULA 200MG TAB (New Starts Only)
- ZEJULA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ZELBORAF 240MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate BRAF V600E or V600 mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ZOLINZA 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ZONISADE 100MG/5ML SUSP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is unable to swallow solid dosage forms of zonisamide.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ZORYVE 0.3% CREAM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis: Trial of a topical corticosteroid was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For plaque psoriasis (all requests): Will not be used in combination with apremilast (Otezla), deucravacitinib (Sotyktu), tapinarof (Vtama) or biologic therapy for the prescribed indication.

Products Affected

– ZTALMY 50MG/ML SUSP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of a CDKL5 gene mutation
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ZURZUVAE 20MG CAP (New Starts Only)
- ZURZUVAE 25MG CAP (New Starts Only)
- ZURZUVAE 30MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month.
Other Criteria	

Products Affected

- ZYDELIG 100MG TAB (New Starts Only)
- ZYDELIG 150MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ZYKADIA 150MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of ALK-positive disease.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	