Abiraterone

Products Affected

- *abiraterone acetate oral tablet 250 mg*
- ZYTIGA ORAL TABLET 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of metastatic castration-resistant prostate cancer (CRPC) OR metastatic high-risk castration-sensitive prostate cancer (CSPC). Abiraterone will be used in combination with prednisone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Actemra

Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	New starts rheumatoid arthritis (RA): patient has moderate to severe disease and had a failure, contraindication, or intolerance to two of the following: Enbrel, Humira, or Xeljanz.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	Renewals: patient has had a positive clinical response to Actemra.
Indications	All FDA-approved Indications.
Off Label Uses	

Acthar

Products Affected
- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	Receipt of live or live attenuated vaccines within 6 weeks of H.P. Acthar Gel, suspected congenital infection (infants), scleroderma, osteoporosis, systemic fungal infection, peptic ulcer disease, ocular herpes simplex, congestive heart failure, recent surgery, uncontrolled hypertension, known hypersensitivity to porcine proteins, primary adrenocortical insufficiency or hyperfunction.
Required Medical Information	For the following diagnoses, patient must have an inadequate response to a trial of parenteral corticosteroids: 1) For rheumatic diseases (e.g., psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis): H.P. Acthar gel must be used as adjunctive treatment, 2) For nephrotic syndrome: H.P. Acthar gel must be requested for induction of diuresis or for remission of proteinuria, 3) For multiple sclerosis (MS): H.P. Acthar gel is being used for MS exacerbation, 4) Collagen diseases (e.g., systemic lupus erythematosus, dermatomyositis, or polymyositis), 5) Dermatologic disorders (e.g., severe erythema multiforme, Stevens-Johnson syndrome), 6) Ophthalmic disorders, acute or chronic (e.g., iritis, keratitis, optic neuritis), 7) Symptomatic sarcoidosis, 8) Serum sickness.
Age Restrictions	For infantile spasms: patient is 2 years of age or younger.
Prescriber Restrictions	
Coverage Duration	IS: 12 months. Collagen and ophthalmic diseases, nephrotic syndrome: 6 months. Others: 1 month
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Adempas

Products Affected
- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of pulmonary arterial hypertension (WHO group I) and diagnosis was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) OR Patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH, WHO group 4) and patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.)
Indications	All FDA-approved Indications.
Off Label Uses	

Aimovig

Products Affected

- AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of either episodic migraines or chronic migraines. For episodic migraine, patient must have both of the following: less than 15 headache days per month and 4-14 migraine days per month. For chronic migraine, patient must have both of the following: at least 15 headache days per month and at least 8 migraine days per month. Patient has had a trial and failure or contraindication to at least 2 different preventative migraine medications.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, pain specialist, or headache specialist
Coverage Duration	Initial: 3 months. Renewal: plan year.
Other Criteria	For renewal, patient must have a positive clinical response.
Indications	All FDA-approved Indications.
Off Label Uses	

Alecensa

Products Affected
- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of metastatic non-small cell lung cancer (NSCLC) with anaplastic lymphoma kinase (ALK) positive disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Alpha1 Proteinase Inhibitor

Products Affected

- ARALAST NP
- GLASSIA
- PROLASTIN-C
- ZEMAIRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of clinically evident emphysema and severe hereditary deficiency of alpha1-antitrypsin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Alunbrig

Products Affected
- ALUNBRIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Ambrisentan

Products Affected
- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Patient has a diagnosis of pulmonary arterial hypertension (WHO Group I). For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy, AND 2) Patient will use reliable contraception during treatment and for one month after stopping treatment
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Armodafinil

Products Affected
- *armodafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome and documentation of residual excessive sleepiness OR Diagnosis of excessive sleepiness associated with narcolepsy and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine) OR Diagnosis of excessive sleepiness associated with shift work disorder.
Age Restrictions	17 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Aubagio

Products Affected
- AUBAGIO

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment. Pregnancy. Concomitant use with leflunomide.
Required Medical Information	Patient has a diagnosis of a relapsing form of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. Serum transaminase and bilirubin levels must be drawn within 6 months prior to initiation of therapy with Aubagio. For female patients of childbearing potential: Pregnancy was excluded prior to initiation of therapy and patient will use reliable contraception during treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Auryxia

Products Affected
- AURYXIA

PA Criteria	Criteria Details
Exclusion Criteria	Auryxia will not be approved for a diagnosis of iron deficiency anemia.
Required Medical Information	Patient has a diagnosis of hyperphosphatemia. Patient has chronic kidney disease and is on dialysis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Austedo

Products Affected
- AUSTEDO

PA Criteria	Criteria Details
Exclusion Criteria	Actively suicidal or has untreated or inadequately treated depression. Impaired hepatic function. Concomitant monoamine oxidase inhibitor (MAOI) or use within 14 days of stopping MAOI. Concomitant reserpine or use within 20 days of stopping reserpine. Concomitant tetrabenazine (Xenazine).
Required Medical Information	Patient has a diagnosis of chorea associated with Huntington's disease OR has a diagnosis of tardive dyskinesia clinically diagnosed with all of the following: involuntary athetoid or choreiform movements, history of treatment with dopamine receptor blocking agent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Ayvakit

Products Affected
- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has unresectable or metastatic gastrointestinal stromal tumors (GIST). Patient has a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Balversa

Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of locally advanced or metastatic urothelial carcinoma. The patient has susceptible FGFR3 or FGFR2 genetic alterations and has progressed during or following at least one line of prior platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Benlysta

Products Affected
- BENLYSTA

PA Criteria	Criteria Details
Exclusion Criteria	Severe active lupus nephritis, severe active CNS lupus, or use of Benlysta in combination with other biologics, including B-cell targeted therapies or intravenous (IV) cyclophosphamide.
Required Medical Information	Patient has active, autoantibody-positive systemic lupus erythematosus (SLE) and is receiving standard therapy (corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) or is not on standard therapy due to past trial and inadequate response or intolerance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Bexarotene

Products Affected
- *bexarotene*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of cutaneous T-cell lymphoma and is refractory to at least 1 prior systemic therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Bosentan

Products Affected

- *bosentan*
- TRACLEER 32 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy. Concomitant use with cyclosporine or glyburide. For initial therapy: alanine aminotransferase (ALT)/aspartate aminotransferase (AST) level greater than 3 times the upper limit of normal (ULN).
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group I) that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.). NYHA Functional Class II to IV symptoms. For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy, and 2) Patient will use reliable contraception during treatment and for one month after stopping treatment
Age Restrictions	Age 3 and older
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Bosulif

Products Affected
- BOSULIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of chronic (newly diagnosed or previously treated), accelerated, or blast phase Philadelphia chromosome-positive chronic myelogenous leukemia (CML). For a diagnosis of accelerated phase or blast phase, patient had resistance or intolerance to prior treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BPH vs ED

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Not covered for the treatment of Erectile Dysfunction. Maximum dose: 5mg daily
Required Medical Information	Patient must have a diagnosis of BPH.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Braftovi

Products Affected
- BRAFTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For a diagnosis of unresectable or metastatic melanoma: patient has a BRAF V600E or V600K mutation, will be used in combination with binimetinib (Mektovi), patient was not previously treated with a BRAF inhibitor or MEK inhibitor. For a diagnosis of metastatic colorectal cancer: patient has a BRAF V600E mutation, will be used in combination with cetuximab, patient has been on prior therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Brukinsa

Products Affected
- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of mantle cell lymphoma and has received at least 1 prior therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Cabometyx

Products Affected

- CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of advanced renal cell carcinoma. Patient has a diagnosis of advanced hepatocellular carcinoma and has been previously treated with sorafenib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Calquence

Products Affected
- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of mantle cell lymphoma and has had at least 1 prior treatment, chronic lymphocytic leukemia (CLL), or small lymphocytic lymphoma (SLL).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Caprelsa

Products Affected
- CAPRELSA

PA Criteria	Criteria Details
Exclusion Criteria	Patient has congenital long QT syndrome.
Required Medical Information	Patient has a diagnosis of symptomatic or progressive medullary thyroid cancer. Patient has unresectable locally advanced or metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Cholbam

Products Affected
- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of a bile acid synthesis disorder due to single enzyme defects (SEDs) OR Cholbam is being used as an adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients with manifestations of liver disease, steatorrhea or complications from decreased fat soluble vitamin absorption.
Age Restrictions	
Prescriber Restrictions	Prescribed by a hepatologist or gastroenterologist.
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Cimzia

Products Affected

- CIMZIA
- CIMZIA PREFILLED KIT
- CIMZIA STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	New starts: Patient has a diagnosis of moderate to severe rheumatoid arthritis and has had a failure, contraindication, or intolerance to two of the following: Enbrel, Humira, or Xeljanz. Patient has a diagnosis of moderate to severe Crohn's disease and has had a failure, contraindication, or intolerance to Humira and one of the following: 6-mercaptopurine, azathioprine, corticosteroid, methotrexate. Patient has a diagnosis of active psoriatic arthritis and has had a failure, contraindication, or intolerance to two of the following: Enbrel, Humira, Otezla, Cosentyx, Stelara. Patient has a diagnosis of active ankylosing spondylitis and has had a failure, contraindication, or intolerance to two of the following: Enbrel, Humira, Cosentyx. Patient has a diagnosis of moderate to severe plaque psoriasis. Patient has a diagnosis of active non-radiographic axial spondyloarthritis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	Renewals: patient has had a positive clinical response to Cimzia.
Indications	All FDA-approved Indications.
Off Label Uses	

Cinryze

Products Affected
- CINRYZE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of hereditary angioedema.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist or another physician that specializes in the treatment of hereditary angioedema
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Cometriq

Products Affected

- COMETRIQ (100 MG DAILY DOSE)
- COMETRIQ (140 MG DAILY DOSE)
- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of progressive, metastatic, medullary thyroid cancer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Copiktra

Products Affected
- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of chronic lymphocytic leukemia, small lymphocytic lymphoma, or follicular lymphoma. Patient has had at least two prior therapies. Prophylaxis for Pneumocystis jirovecii (PJP) will be provided during treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Cotellic

Products Affected
- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation. Cobimetinib will be used in combination with vemurafenib (Zelboraf).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Dalfampridine

Products Affected
- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	Moderate to severe renal impairment (CrCL less than or equal to 50 mL/min) and/or history of seizures.
Required Medical Information	Patient must have the ability to walk 25 feet (with or without assistance) prior to starting dalfampridine. Patient has a diagnosis of multiple sclerosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	To continue therapy, the patient must experience improvement in walking speed or other objective measure of walking ability since starting dalfampridine. Dalfampridine at doses exceeding 10mg twice daily are not covered.
Indications	All FDA-approved Indications.
Off Label Uses	

Daurismo

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of acute myeloid leukemia (AML) and is newly diagnosed. Daurismo (glasdegib) will be used in combination with low-dose cytarabine. Patient is 75 years old or older OR has comorbidities that precludes the use of intensive induction chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Deferasirox

Products Affected

- *deferasirox*
- *deferasirox granules*
- JADENU SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	Patients with an eGFR less than 40mL/min/1.73m2. Patient's with a platelet count less than 50 million/L.
Required Medical Information	(1) For chronic iron overload due to blood transfusions, Diagnosis of chronic iron overload due to blood transfusions and current serum ferritin level greater than 1000 mcg/L. (2) For iron overload in patients with NON-transfusion-dependent thalassemia (NTDT), a) Diagnosis of a NON-transfusion thalassemia syndrome and chronic iron overload, b)For initiation: i) pretreatment LIC of at least 5 mg per gram of dry weight and ii) pretreatment serum ferritin levels greater than 300 mcg/L and iii) For patients currently on deferasirox therapy: current LIC is greater than 3 mg per gram of dry weight or deferasirox will be withheld until the LIC reaches above 5 mg per gram of dry weight.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Deferiprone

Products Affected
- FERRIPROX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of transfusion-related iron overload due to thalassemia syndromes.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Diclofenac

Products Affected

- *diclofenac sodium transdermal gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have a diagnosis of actinic keratosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Diclofenac Epolamine

Products Affected

- *diclofenac epolamine transdermal patch 1.3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has acute pain due to minor strains, sprains, or contusions.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Dupixent

Products Affected
- DUPIXENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For a diagnosis of moderate to severe atopic dermatitis: patient has tried and failed or has contraindications to at least two topical prescription therapies from the following classes: medium to high potency corticosteroid or calcineurin inhibitor. For a diagnosis of moderate to severe asthma: patient has an eosinophilic phenotype or has corticosteroid dependent asthma. For a diagnosis of chronic rhinosinusitis with nasal polyposis, will be used as an add on maintenance treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Enbrel

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Epclusa

Products Affected

- EPCLUSA ORAL TABLET 400-100 MG
- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Information required for review: genotype, prior treatments, cirrhosis status (including Child-Pugh class), desired treatment regimen, viral load, HIV status, liver transplant history. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines with the highest evidence rating in that category as of the date of the request. In cases where the request is for a lower evidence rated treatment, an explanation will be required as to why the higher rated regimen is not preferred.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Epidiolex

Products Affected
- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex (TSC).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Epoetin

Products Affected

- PROCRIT
- RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Determine if ESRD (B vs D) Patient has one of the following diagnosis: anemia associated with chronic renal failure, anemia associated with chemotherapy, Anemia secondary to zidovudine in HIV-infected patients, Reduction of allogeneic RBC transfusion in patients undergoing elective, non cardiac, non vascular surgery
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Erivedge

Products Affected
- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of metastatic basal cell carcinoma OR has a diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Erleada

Products Affected
- ERLEADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has non-metastatic, castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer. Patient will also be on concurrent gonadotropin-releasing hormone (GnRH) analog or had a bilateral orchiectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Erlotinib

Products Affected
- *erlotinib hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For pancreatic cancer: Used first-line in locally advanced, unresectable, or metastatic cancer in combination with gemcitabine. For metastatic non-small cell lung cancer: not used in combination with platinum-based chemotherapy, tumors have EGFR exon 19 deletions or exon 21 substitution mutations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Esbriet

Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has a diagnosis of idiopathic pulmonary fibrosis. Liver function tests were performed prior to starting therapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	Plan year
Other Criteria	For renewal, the patient has not experienced AST or ALT elevations greater than 5 times the upper limit of normal or greater than 3 times the upper limit of normal with signs or symptoms of severe liver damage.
Indications	All FDA-approved Indications.
Off Label Uses	

Everolimus

Products Affected

- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG
- *everolimus oral tablet 2.5 mg, 5 mg, 7.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of advanced metastatic renal cell carcinoma and patient has failed therapy (disease progressed) with Sutent or Nexavar OR Diagnosis of progressive pancreatic neuroendocrine tumors (pNET) that are unresectable OR progressive, well-differentiated, nonfunctional GI or lung endocrine tumors in patients with unresectable, locally advanced or metastatic disease OR Diagnosis of renal angiomyolipoma with tuberous sclerosis complex (TSC) and patient does not require immediate surgery OR Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer and patient is a postmenopausal woman and patient has failed treatment with Femara or Arimidex and the medication will be used in combination with Aromasin OR Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but is not a candidate for curative surgical resection OR diagnosis of tuberous sclerosis complex (TSC)-associated partial-onset seizures.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Farydak

Products Affected
- FARYDAK

PA Criteria	Criteria Details
Exclusion Criteria	History of recent myocardial infarction or unstable angina, QTcF greater than 450 msec or significant baseline ST-segment or T-wave abnormalities.
Required Medical Information	Patient must have multiple myeloma and received at least 2 prior regimens, including bortezomib and an immunomodulatory agent. Must be used in combination with bortezomib and dexamethasone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	For renewals: Patient must have clinical benefit. Patient must not have experienced unresolved severe or medically significant toxicity. Total treatment duration will not exceed 16 cycles (48 weeks).
Indications	All FDA-approved Indications.
Off Label Uses	

Fasenra

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has severe asthma with an eosinophilic phenotype. Patient is maintained with high dose inhaled corticosteroid or with medium to high dosed inhaled corticosteroid with a long-acting beta agonist (LABA). Patient has had at least two exacerbations in the past year or at least one exacerbation in the prior year while on daily oral corticosteroid treatment.
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Fintepla

Products Affected
- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of seizures associated with Dravet syndrome
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Gattex

Products Affected
- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Short Bowel Syndrome (SBS) (Initial): Diagnosis of SBS. Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is dependent on parenteral nutrition/intravenous (PN/IV) support for at least 12 months.
Age Restrictions	
Prescriber Restrictions	SBS (Init, reauth): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	SBS (Init): 6 months. SBS (Reauth): 12 months.
Other Criteria	SBS (Reauth): Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has had a reduction in weekly parenteral nutrition/intravenous (PN/IV) support from baseline while on therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

Gilenya

Products Affected
- GILENYA ORAL CAPSULE 0.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Recent occurrence (within the last 6 months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, class III or IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Baseline QTc interval greater than or equal to 500ms. Treatment with Class Ia or Class III anti-arrhythmic drugs.
Required Medical Information	Patient has a diagnosis of a relapsing form of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Gilotrif

Products Affected
- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of previously untreated metastatic non-small cell lung cancer (NSCLC) with tumors expressing non-resistant epidermal growth factor receptor mutations. OR Patient has a diagnosis of metastatic squamous NSCLC and has been previously treated with platinum-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Growth hormone

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- HUMATROPE
- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION 10 MG/1.5ML, 15 MG/1.5ML, 30 MG/3ML, 5 MG/1.5ML
- NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION 10 MG/2ML
- NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION 20 MG/2ML
- NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION 5 MG/2ML
- OMNITROPE SUBCUTANEOUS SOLUTION 10 MG/1.5ML, 5 MG/1.5ML
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED
- SAIZEN
- SAIZENPREP
- SEROSTIM
- ZOMACTON
- ZORBTIVE

PA Criteria	Criteria Details
Exclusion Criteria	Closed epiphyses in pediatric patients. Acute critical illness due to complications following open heart or abdominal surgery, multiple accidental trauma or acute respiratory failure. Active malignancy. Active proliferative or severe non-proliferative diabetic retinopathy. For Prader-Willi Syndrome only: severe obesity, history of upper airway obstruction or sleep apnea, or severe respiratory impairment.
Required Medical Information	For CRI: patient is not post-kidney transplant. For TS: diagnosis confirmed by karyotyping. For PWS: diagnosis confirmed by genetic testing. For pediatric GHD, CRI, SHOXD, and NS, patient must meet one of the following: 1) height more than 3 SDS below mean for age and gender 2) Height more than 2 SDS below mean with growth velocity more than 1 SDS below mean, or 3) Growth velocity over 1 year 2 SDS below mean. For adult GHD: must meet one of the following: 1) Failed 2 standard GH stimulation tests 2) Panhypopituitarism or 3 or more pituitary hormone deficiencies 3) Childhood-onset GHD with known mutations, embryopathic lesions, or irreversible structural lesions/damage 4) Low pre-treatment IGF-1 and failed 1 stimulation test prior to starting treatment
Age Restrictions	For SGA: patient is more than 2 years old.
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	For renewal of pediatric indications: final adult height has not been reached. For renewal of adult indications, patient has experienced an

PA Criteria	Criteria Details
	improvement or normalization of IGF-1 levels (not applicable to patients with panhypopituitarism)
Indications	All FDA-approved Indications.
Off Label Uses	

Harvoni

Products Affected

- HARVONI
- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Information required for review: genotype, prior treatments, cirrhosis status, desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines as of the date of the request.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 or 24 weeks. 8 weeks per prescriber discretion
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Hetlioz

Products Affected
- HETLIOZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of non-24-hour sleep-wake disorder. Patient is totally blind in both eyes and unable to perceive light. For renewals: patient must experience an increase in total nighttime sleep or decreased daytime nap duration.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 3 months, Renewal: plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

HRM - Antidiabetics

Products Affected

- *glyburide micronized*
- *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*
- *glyburide-metformin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient tried and failed to at least one of the following: glipizide, glipizide/metformin, or has contraindications to all alternatives.
Age Restrictions	Applies to patients 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	Patient will be monitored for hypoglycemia. Conservative dosing will be used to minimize hypoglycemic events.
Indications	All FDA-approved Indications.
Off Label Uses	

HRM - Digoxin

Products Affected

- *digitek oral tablet 250 mcg*
- *digox oral tablet 250 mcg*
- *digoxin oral tablet 250 mcg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has tried a lower dose (less than or equal to 0.125mg daily) or has contraindications to a lower dose.
Age Restrictions	Applies to patients 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	The patient has been counseled on and does not have signs and symptoms of toxicity.
Indications	All FDA-approved Indications.
Off Label Uses	

HRM - Muscle Relaxants

Products Affected

- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine hcl oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The prescriber must attest that the medication benefits outweigh the potential risks.
Age Restrictions	Applies to patients 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Ibrance

Products Affected
- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has hormone receptor (HR)-positive, HER2-negative advanced or metastatic breast cancer. Ibrance will be used with an aromatase inhibitor as initial endocrine based therapy in postmenopausal women or in men OR with fulvestrant in women with disease progression following endocrine therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Icatibant

Products Affected
- *icatibant acetate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of hereditary angioedema. Icatibant will be used for acute attacks of angioedema. Patient has been advised to seek immediate medical attention in addition to treatment with icatibant. Patient has been counseled to use no more than 3 doses in a 24 hour period.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Iclusig

Products Affected
- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	Patient must not have newly diagnosed chronic phase CML.
Required Medical Information	Patient has chronic myeloid leukemia (CML) and is T315I-positive, OR patient has T315I-positive Philadelphia chromosome positive acute lymphoblastic leukemia (ALL), OR patient has CML or Philadelphia chromosome positive ALL for whom no other tyrosine kinase inhibitor is indicated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Idhifa

Products Affected
- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of relapsed or refractory acute myeloid leukemia (AML). Patient has an isocitrate dehydrogenase-2 (IDH2) mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Imatinib

Products Affected

- *imatinib mesylate oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of one of the following in an adult: A) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), B) Ph+ acute lymphoblastic leukemia (ALL), C) Myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, D) Aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown, E) Hypereosinophilic syndrome or chronic eosinophilic leukemia, F) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, G) Gastrointestinal tumor (GIST) where patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST or patient had resection of c-KIT positive GIST and imatinib will be used as an adjuvant therapy. Diagnosis of one of the following in a pediatric patient: A) Ph+ CML that is newly diagnosed in the chronic phase B) newly diagnosed Ph+ ALL.
Age Restrictions	18 years of age or younger - newly diagnosed CML in the chronic phase or newly diagnosed Ph+ ALL. 18 years of age or older for other indications.
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Imbruvica

Products Affected
- IMBRUVICA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of mantle cell lymphoma (MCL) and patient has received at least one prior therapy. Diagnosis of chronic lymphocytic leukemia (CLL). Diagnosis of CLL with 17p deletion. Diagnosis of Waldenstrom's macroglobulinemia (WM). Diagnosis of marginal zone lymphoma in patients that have received at least one prior anti-CD20-based therapy such as rituximab. Diagnosis of chronic graft-versus-host disease after failure of one or more lines of systemic therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Ingrezza

Products Affected
- INGREZZA

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant monoamine oxidase inhibitor (MAOI) or tetrabenazine.
Required Medical Information	Patient has been clinically diagnosed with moderate to severe tardive dyskinesia including involuntary athetoid or choreiform movements.
Age Restrictions	
Prescriber Restrictions	Ingrezza is prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	Plan year
Other Criteria	For renewal, patient must have improvement in symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	

Inlyta

Products Affected
- INLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of advanced renal cell carcinoma (RCC). Patient has failed one prior systemic therapy, OR patient will use in combination with avelumab or pembrolizumab for first line treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Inqovi

Products Affected
- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of Myelodysplastic syndrome (MDS). Patient has one of the following French- American-British subtypes: refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, or chronic myelomonocytic leukemia (CMML).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Inrebic

Products Affected
- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of intermediate-2 or high risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF). Thiamine level was assessed prior to starting treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Invega Trinza

Products Affected
- INVEGA TRINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have a diagnosis of schizophrenia. Patient must have been adequately treated with Invega Sustenna for at least 4 months. Invega Trinza will only be given once every 3 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Iressa

Products Affected
- IRESSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has metastatic non-small cell lung cancer. The tumors have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations. Patient is using Iressa first line.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IVIG

Products Affected

- BIVIGAM
- FLEBOGAMMA DIF
- GAMMAGARD
- GAMMAKED
- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 20 GM/400ML, 5 GM/50ML
- GAMUNEX-C
- PRIVIGEN

PA Criteria	Criteria Details
Exclusion Criteria	History of hypersensitivity to immune globulin or any component of the preparation.
Required Medical Information	For a diagnosis of ITP: patient must have a trial of corticosteroids unless platelet count is less than 20,000 cells/mm3 and bleeding has occurred. For a diagnosis of hypogammaglobulinemia associated with B-cell chronic lymphocytic leukemia: IgG level is less than 500 mg/dL or patient has a history of infection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Indications	All Medically-accepted Indications.
Off Label Uses	

Jakafi

Products Affected
- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of intermediate or high-risk myelofibrosis (including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis). OR Patient has a diagnosis of polycythemia vera and has had an inadequate response to or was intolerant of hydroxyurea. OR Patient has a diagnosis of acute graft-versus-host disease (GVHD) and has failed steroids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Juxtapid

Products Affected
- JUXTAPID

PA Criteria	Criteria Details
Exclusion Criteria	For initiation of treatment, moderate or severe hepatic impairment (eg, Child-Pugh B or C). For renewal, ALT or AST equal to or greater than 5 times the upper limit normal (ULN), or equal to greater than 3x ULN with signs or symptoms of liver toxicity or injury, increases in bilirubin greater than 2x ULN or active liver disease.
Required Medical Information	For initiation of therapy, 1. Patient has a diagnosis of homozygous familial hypercholesterolemia confirmed by one of the following: A. documented mutations in both alleles at LDL receptor, ApoB, PCSK9, or ARH adapter protein gene locus, B. documented skin fibroblast LDL receptor activity less than 20% of normal, OR C. the following criteria are met: a) untreated LDL-C greater than 500 mg/dL or unknown AND b) triglyceride level less than 350 mg/dL AND c) tendon or cutaneous xanthomas at age 10 or younger OR d) both parents with a history of LDL-C greater than 190 mg/dL, AND 2. Patient has tried and had an inadequate response or intolerance to the maximum tolerated dose of a high potency statin and a PCSK9 inhibitor unless contraindicated. For renewal of therapy, 1. Patient meets all initial criteria AND 2. Current LDL-C is improved from the levels immediately prior to initiation of treatment with Juxtapid.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Kalydeco

Products Affected
- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Statement from physician or lab results showing patient has cystic fibrosis with a CFTR gene mutation responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. Patient is not homozygous for the F508del mutation in the CFTR gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Kevzara

Products Affected
- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	Patient has an ANC less than 2,000/mm3, platelet count less than 150,000/mm3, or ALT and AST are more than 1.5 times the upper limit of normal.
Required Medical Information	Patient has a diagnosis of moderately to severely active rheumatoid arthritis. Patient has had an inadequate response, contraindication, or intolerance to at least 2 of the following: Humira, Enbrel, Xeljanz.
Age Restrictions	Patient is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Kisqali

Products Affected

- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)
- KISQALI FEMARA (400 MG DOSE)
- KISQALI FEMARA (600 MG DOSE)
- KISQALI FEMARA(200 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of hormone receptor positive, human epidermal growth factor receptor 2 negative advanced or metastatic breast cancer. Patient will use as initial endocrine-based therapy in combination with an aromatase inhibitor OR patient is postmenopausal and will use in combination with fulvestrant. Concomitant use with fulvestrant does not apply to Kisqali Femara Co-Pack requests.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Korlym

Products Affected
- KORLYM

PA Criteria	Criteria Details
Exclusion Criteria	Not covered if patient is pregnant. Maximum dose: 1200mg daily, not to exceed 20mg/kg/day. Patient requires concomitant treatment with long-term corticosteroids (e.g., immunosuppression for organ transplant). History of unexplained vaginal bleeding. Endometrial hyperplasia with atypia or endometrial carcinoma. Concomitantly taking simvastatin, lovastatin, or a CYP3A substrate with a narrow therapeutic range (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, or tacrolimus)
Required Medical Information	Patient has a diagnosis of endogenous Cushing's syndrome and has type 2 diabetes mellitus or glucose intolerance. Patient has failed surgery or is not a candidate for surgery. Statement from physician verifying that non-hormonal contraception will be used during treatment and for one month after discontinuation of therapy unless the patient has had surgical sterilization.
Age Restrictions	
Prescriber Restrictions	Prescribing physician must be an endocrinologist
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Koselugo

Products Affected
- KOSELUGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of neurofibromatosis type 1 and has symptomatic, inoperable plexiform neurofibromas.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Kuvan

Products Affected
- KUVAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has hyperphenylalaninemia due to Phenylketonuria (PKU).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Lenvima

Products Affected

- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer. OR Patient has a diagnosis of advanced renal cell carcinoma (RCC) and has failed one prior anti-angiogenic therapy, OR patient has a diagnosis of unresectable hepatocellular carcinoma (HCC) OR patient has a diagnosis of advanced endometrial carcinoma and will be used with pembrolizumab and does not have microsatellite instability-high or mismatch repair deficient and has had disease progression following prior systemic therapy. Lenvima will be used in combination with everolimus when used for RCC.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Lidoderm

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has a diagnosis of post-herpetic neuralgia, diabetic neuropathy, or cancer-related neuropathic pain. The patch will only be applied to intact skin
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Diabetic neuropathy, cancer-related neuropathic pain.

Lonsurf

Products Affected
- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For a diagnosis of metastatic colorectal cancer: patient has been previously treated with a fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy (such as FOLFOX, FOLFIRI, FOLFOXIRI) AND an anti-VEGF biological therapy (such as Avastin), if patient is RAS wild-type, patient has been previously treated with an anti-EGFR therapy. For a diagnosis of metastatic gastric or gastroesophageal junction adenocarcinoma: patient has been treated with at least two prior lines of chemotherapy which included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Lorbrena

Products Affected
- LORBRENA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of anaplastic lymphoma kinase (ALK) positive metastatic non-small cell lung cancer (NSCLC). Patient has progressed on one of the following: crizotinib and at least one other ALK inhibitor for metastatic disease, or alectinib as the first ALK inhibitor therapy for metastatic disease, or certinib as the first ALK inhibitor therapy for metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Lynparza

Products Affected
- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of one of the following: recurrent ovarian cancer (epithelial, fallopian tube, or primary peritoneal) after platinum-based chemotherapy. OR Patient has a diagnosis of advanced ovarian cancer with deleterious or suspected deleterious germline BRCA-mutations and has been treated with 3 or more prior lines of chemotherapy. OR Patient has a diagnosis of deleterious or suspected deleterious germline or somatic BRCA-mutated advanced epithelial ovarian, fallopian tube or primary peritoneal cancer who are in complete or partial response to first-line platinum based chemotherapy. OR Patient has a diagnosis of metastatic HER-2 negative breast cancer with deleterious or suspected deleterious germline BRCA-mutations and has been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting. OR Patient has a diagnosis of patient has metastatic pancreatic adenocarcinoma with deleterious or suspected deleterious germline BRCA mutation who had at least 16 weeks of a first-line platinum-based chemotherapy regimen without disease progression. OR Patient has a diagnosis of advanced epithelial ovarian, fallopian tube or primary peritoneal cancer after a complete or partial response to first-line platinum-based chemotherapy, olaparib will be used in combination with bevacizumab, cancer is associated with homologous recombination deficiency (HRD)-positive status defined by either a deleterious or suspected deleterious BRCA mutation, genomic instability. OR Patient has a diagnosis of deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer and disease has progressed following prior treatment with enzalutamide or abiraterone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.

Last updated: October 2020
Formulary ID: 21484, 21485, Version 7
Effective Date: 01/01/2021

PA Criteria	Criteria Details
Off Label Uses	

Mavyret

Products Affected
- MAVYRET

PA Criteria	Criteria Details
Exclusion Criteria	Patient does not have moderate to severe hepatic impairment (Child-Pugh B or C).
Required Medical Information	Information required for review: genotype, prior HCV treatments, cirrhosis status (including Child-Pugh class), desired treatment regimen, viral load, HIV status, liver transplant history. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines with the highest evidence rating in that category as of the date of the request. In cases where the request is for a lower evidence rated treatment, an explanation will be required as to why the higher rated regimen is not preferred.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	8, 12, or 16 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Mayzent

Products Affected
- MAYZENT

PA Criteria	Criteria Details
Exclusion Criteria	Patients with CYP2C9 3/3, one of the following within the last 6 months: MI, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, Class III or IV HF, Mobitz Type II second degree, third degree AV block, or sick sinus syndrome unless pt has a functioning pacemaker
Required Medical Information	Patient has been tested for CYP2C9 variants. If the patients has CYP2C9 1/3 or 2/3 the patient will be maintained on 1mg daily.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Mekinist

Products Affected
- MEKINIST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has unresectable or metastatic melanoma with BRAF V600E or V600K mutations and Mekinist will be used as a single agent or with dabrafenib (Tafinlar) and patient has not received prior BRAF-inhibitor therapy (Zelboraf, Tafinlar), OR patient has melanoma with BRAF V600E or V600K mutations and involvement of lymph nodes and Mekinist will be used as adjuvant treatment with dabrafenib after complete resection and has not received prior BRAF-inhibitor therapy, OR patient has a diagnosis of BRAF V600E mutation positive metastatic non-small cell lung cancer and will use in combination with dabrafenib, OR patient has a diagnosis of BRAF V600E mutation-positive locally advanced or metastatic anaplastic thyroid cancer and will be used in combination with dabrafenib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Mektovi

Products Affected
- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation. Binimetinib (Mektovi) will be used in combination with encorafenib (Braftovi). Patient was not previously treated with a BRAF inhibitor or MEK inhibitor.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Miglustat

Products Affected
- *miglustat*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of mild to moderate type 1 Gaucher disease. Enzyme replacement therapy is not a therapeutic option due to allergy, hypersensitivity, or poor venous access. Miglustat will be used as monotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Nerlynx

Products Affected
- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of early stage HER2-overexpressed breast cancer and has been on trastuzumab based therapy OR patient has a diagnosis of advanced or metastatic HER2-positive breast cancer and has received 2 or more prior anti-HER2 based regimens and will be used in combination with capecitabine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Nexavar

Products Affected
- NEXAVAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of one of the following: unresectable hepatocellular carcinoma, advanced renal cell carcinoma, or locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Ninlaro

Products Affected
- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of multiple myeloma. Ixazomib will be used in combination with lenalidomide and dexamethasone. Patient has received at least one prior therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Northera

Products Affected
- NORTHERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have a diagnosis of neurogenic orthostatic hypotension caused by primary autonomic failure (due to Parkinson disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, and nondiabetic autonomic neuropathy. Patient must also have tried midodrine.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a neurologist.
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Nubeqa

Products Affected
- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has non-metastatic, castration-resistant prostate cancer. Patient will also be on concurrent gonadotropin-releasing hormone (GnRH) analog or had a bilateral orchiectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Nucala

Products Affected
- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of severe asthma with an eosinophilic phenotype and mepolizumab (Nucala) will be used as add-on treatment. For asthma: patient is maintained with high dose inhaled corticosteroid or with medium to high dosed inhaled corticosteroid with a long-acting beta agonist (LABA), and patient has had at least two exacerbations in the past year or at least one exacerbation in the prior year while on daily oral corticosteroid treatment. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Nuedexta

Products Affected
- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	Patient is currently using quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong the QT interval and are metabolized by CYP2D6 (examples: thioridazine and pimozide). Patient has a prolonged QT interval or congenital long QT syndrome (LQTS), or heart failure or a history suggestive of torsades de pointes (TdP). Patient has complete atrioventricular (AV) block without an implanted pacemaker or is at high risk of complete AV block.
Required Medical Information	Diagnosis of pseudobulbar affect (PBA).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Nuplazid

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG, 17 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of Parkinson's disease and is experiencing at least one of the following: hallucinations, delusions.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Odomzo

Products Affected
- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of locally advanced basal cell carcinoma (BCC). BCC has either recurred following surgery or radiation therapy or patient was not a candidate for surgery or radiation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Ofev

Products Affected
- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has a diagnosis of idiopathic pulmonary fibrosis, chronic fibrosing interstitial lung diseases with a progressive phenotype, or a diagnosis of systemic sclerosis-associated interstitial lung disease. Liver function tests were performed prior to starting therapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	Plan year
Other Criteria	For renewal, the patient has not experienced AST or ALT elevations greater than 5 times the upper limit of normal or greater than 3 times the upper limit of normal with signs or symptoms of severe liver damage.
Indications	All FDA-approved Indications.
Off Label Uses	

Opsumit

Products Affected
- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has pulmonary arterial hypertension (PAH), World Health Organization Group I disease. PAH was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.). Liver function tests were performed prior to starting therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Orencia

Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	New starts: Patient has a diagnosis of moderate to severe rheumatoid arthritis and has had a failure, contraindication, or intolerance to two of the following: Enbrel, Humira, Xeljanz. Patient has a diagnosis of moderate to severe juvenile idiopathic arthritis and has had a failure, contraindication, or intolerance to both Enbrel and Humira. Patient has a diagnosis of active psoriatic arthritis and has had a failure, contraindication, or intolerance to two of the following: Enbrel, Humira, Otezla, Cosentyx, Stelara.
Age Restrictions	Juvenile idiopathic arthritis: IV: 6 years and older . SC: 2 years and older.
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	Renewals: patient has had a positive clinical response to Orencia.
Indications	All FDA-approved Indications.
Off Label Uses	

Orenitram

Products Affected
- ORENITRAM

PA Criteria	Criteria Details
Exclusion Criteria	Patient has a diagnosis of severe hepatic impairment (Child Pugh Class C).
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Orkambi

Products Affected
- ORKAMBI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has cystic fibrosis and is homozygous for the F508del mutation in the CFTR gene. Patient had baseline ALT, AST, and bilirubin assessed.
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Osphena

Products Affected
- OSPHENA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dyspareunia (initial): Diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause. Vaginal dryness (initial): Diagnosis of moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	All uses (Initial, reauth): 12 months
Other Criteria	Dyspareunia, Vaginal dryness (reauth): Documentation of positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

Oxandrolone

Products Affected

- *oxandrolone oral tablet 10 mg, 2.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Adjunctive therapy for severe burns, AIDS related cachexia.

Pemazyre

Products Affected
- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement. Patient has been previously treated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Piqray

Products Affected

- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of metastatic breast cancer. Patient has HR postive and HER2 negative markers. Patient has PIK3CA mutated disease. Progressed on or after endocrine based regimen. Piqray will be used with fulvestrant.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Pomalyst

Products Affected
- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For multiple myeloma: 1) Patient received prior therapy with Velcade (bortezomib) AND Revlimid (lenalidomide), 2) disease has progressed during or within 60 days of completion of last therapy 3) Will be used in combination with dexamethasone. For Kaposi sarcoma (KS): patient has AIDS-related KS after failure of highly active antiretroviral therapy or patient is HIV-negative.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Praluent

Products Affected
- PRALUENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of primary hyperlipidemia or alirocumab will be used to reduce the risk of myocardial infarction, stroke, and unstable angina requiring hospitalization in patients with established cardiovascular disease. Patient is on maximally tolerated statin therapy or has zero tolerance to statin therapy. Patient will be started on the 75mg dose. For a diagnosis of clinical atherosclerotic cardiovascular disease or primary hyperlipidemia: patient has tried at least two statins (rosuvastatin, atorvastatin, simvastatin, pravastatin, lovastatin, or fluvastatin)
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Promacta

Products Affected
- PROMACTA

PA Criteria	Criteria Details
Exclusion Criteria	Use in the management of thrombocytopenia in myelodysplastic syndrome (MDS).
Required Medical Information	Patient has a diagnosis of chronic immune thrombocytopenic purpura (ITP) and meets both of the following: baseline platelet count less than 50,000/mcL, had an insufficient response to either corticosteroids, immunoglobulins, or splenectomy. Patient has a diagnosis of severe aplastic anemia with a platelet count less than 30,000/mcL. Patient has a diagnosis of thrombocytopenia in a patient with chronic hepatitis C.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Provigil

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome and documentation of residual excessive sleepiness OR Diagnosis of excessive sleepiness associated with narcolepsy and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine) OR Diagnosis of excessive sleepiness associated with shift work disorder.
Age Restrictions	17 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Qinlock

Products Affected
- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of advanced gastrointestinal stromal tumor (GIST). Patient has received 3 or more prior kinase inhibitors, including imatinib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Quinine

Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of uncomplicated Plasmodium falciparum malaria, uncomplicated Plasmodium vivax malaria, or babesiosis. Patient is not prescribed quinine for the treatment or prevention of leg cramps.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Babesiosis, uncomplicated Plasmodium vivax malaria.

Regranex

Products Affected
- REGRANEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has diabetes. Patient has neuropathic ulcers on the lower extremity that extend into the subcutaneous tissue or beyond and have an adequate blood supply (i.e. is not an ischemic ulcer).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	20 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Relistor

Products Affected
- RELISTOR

PA Criteria	Criteria Details
Exclusion Criteria	Patient with known or suspected mechanical GI obstruction and at increased risk of recurrent obstruction.
Required Medical Information	Patient has a diagnosis of opioid induced constipation with either chronic non cancer pain or advanced illness or pain caused by cancer who are receiving palliative care, when response to laxative therapy has not been sufficient. Patient has had an inadequate response to Amitiza or Movantik.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Repatha

Products Affected

- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of heterozygous or homozygous familial hypercholesterolemia (HeFH or HoFH), primary hyperlipidemia, or clinical atherosclerotic cardiovascular disease (ASCVD, defined as having at least one of the following: ACS, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin) and requires additional lowering of LDL cholesterol. Patient is on maximally tolerated statin therapy or has zero tolerance to statin therapy. For a diagnosis of clinical atherosclerotic cardiovascular disease or primary hyperlipidemia: patient has tried at least two statins (rosuvastatin, atorvastatin, simvastatin, pravastatin, lovastatin, or fluvastatin).
Age Restrictions	13 years of age or older for HoFH, 18 years of age or older for other indications
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Respiratory PDE-5 Inhibitor

Products Affected

- *alyq*
- *sildenafil citrate oral suspension reconstituted*
- *sildenafil citrate oral tablet 20 mg*
- *tadalafil (pah)*

PA Criteria	Criteria Details
Exclusion Criteria	Receiving nitrate therapy (includes intermittent use)
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has (WHO Group I) PAH.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Retevmo

Products Affected
- RETEVMO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer with RET fusion-positive disease. OR patient has a diagnosis of advanced or metastatic RET-mutant medullary thyroid cancer. OR patient has a diagnosis of advanced or metastatic RET fusion-positive thyroid cancer and is refractory to radioactive iodine (if radioactive iodine is appropriate).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Revlimid

Products Affected
- REVLIMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of multiple myeloma and medication will be used in combination with dexamethasone or as maintenance therapy after autologous hematopoietic stem cell transplant. OR Diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5 q cytogenetic abnormality with or without additional cytogenetic abnormalities. OR Diagnosis of mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib. AND Patient is not using the medication for the treatment of chronic lymphocytic leukemia. OR Patient has a diagnosis of follicular or marginal zone lymphoma that has been previously treated and will be used with a rituximab product.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Rozlytrek

Products Affected
- ROZLYTREK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer with ROS1-positive tumors. OR Patient has solid tumors that meet the following: have a neutrotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, patient has either progressed following treatment or has no satisfactory alternative therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Rubraca

Products Affected
- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer with deleterious BRCA mutation and has been treated with 2 or more chemotherapies OR rucaparib will be used for the maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer after a complete or partial response to platinum-based chemotherapy. OR Patient has a diagnosis of metastatic castration resistant prostate cancer with a deleterious BRCA mutation and has been treated with androgen receptor directed therapy and taxane based chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Rydapt

Products Affected
- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of new onset acute myeloid leukemia (AML) that is FLT3 mutation positive, aggressive systemic mastocytosis, systemic mastocytosis with associated hematological neoplasm, mast cell leukemia. For patients with AML, midostaurin will be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy. Midostaurin will not be used as a single-agent induction for AML.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Somatuline

Products Affected

- SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of either Acromegaly or gastroenteropancreatic neuroendocrine tumors (GEP-NETs), or carcinoid syndrome. For acromegaly, patient has had an inadequate or partial response to surgery and/or radiotherapy or patient was not a candidate for surgery or radiotherapy. For GEP-NETs, tumors are unresectable, well- or moderately-differentiated, locally advanced or metastatic.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Sprycel

Products Affected
- SPRYCEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Newly diagnosed adults with Philadelphia chromosome-positive chronic myelogenous leukemia (CML) in chronic phase. Adults with chronic, accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome-positive CML with resistance or intolerance to prior therapy including imatinib. Adults with diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (ALL) with resistance or intolerance to prior therapy. Pediatric patients with a diagnosis of Philadelphia chromosome-positive CML in chronic phase or newly diagnosed Philadelphia chromosome-positive ALL in combination with chemotherapy. For patients with GIST, patient must have progressed on imatinib or sunitinib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Gastrointestinal stromal tumor (GIST).

Stivarga

Products Affected
- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of: A) metastatic colorectal cancer AND patient has previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan -based therapy, an anti-vascular endothelial growth factor (VEGF) therapy, and, if KRAS wild type, an anti-epidermal growth factor receptor (EGFR) therapy or B) gastrointestinal stromal tumors that is locally advanced, unresectable or metastatic AND patient has tried and had an inadequate response, contraindication or intolerance to imatinib and sunitinib or C) hepatocellular carcinoma and has been previously treated with sorafenib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Sutent

Products Affected
- SUTENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of advanced/metastatic renal cell carcinoma or as an adjuvant treatment after nephrectomy. Diagnosis of gastrointestinal stromal tumor (GIST) after disease progression on or intolerance to imatinib. Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) in a patient with unresectable locally advanced or metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Symdeko

Products Affected
- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has cystic fibrosis and is homozygous for the F508del mutation or has at least 1 mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence. Patient had baseline ALT and AST assessed.
Age Restrictions	6 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Symlin

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of type 1 or type 2 diabetes mellitus. Patient is currently receiving optimal mealtime insulin therapy. Patient has had an inadequate treatment response to insulin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Tabrecta

Products Affected
- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer whose tumors have a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Tafinlar

Products Affected
- TAFINLAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation and will be used in combination with trametinib, OR a diagnosis of unresectable or metastatic melanoma AND will be used as monotherapy in patients with the BRAF V600E mutation OR dabrafenib will be used in combination with trametinib in patients with BRAF V600E or V600K mutations, OR patient has a diagnosis of melanoma with BRAF V600E or V600K mutations with lymph node involvement and will be used in combination with trametinib after complete resection, OR patient has a diagnosis of locally advanced or metastatic anaplastic thyroid cancer with BRAF V600E mutations and will be used with trametinib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Tagrisso

Products Affected
- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) T790M mutation-positive disease. Patient must have progressed on or after EGFR tyrosine kinase inhibitor (TKI) therapy OR patient has a diagnosis of metastatic NSCLC with EGFR exon 19 deletions or exon 21 L858R mutations and Tagrisso will be used first line.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Talzenna

Products Affected
- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of locally advanced or metastatic breast cancer. Patient has deleterious or suspected deleterious germline breast cancer susceptibility gene (BRCA)-mutated human epidermal growth factor receptor 2 (HER2) negative disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Targretin

Products Affected
- TARGRETIN EXTERNAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For gel: patient has a diagnosis of stage 1A or 1B cutaneous T-cell lymphoma that is refractory or persistent after treatment with other therapies or has not tolerated other therapies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Tasigna

Products Affected
- TASIGNA

PA Criteria	Criteria Details
Exclusion Criteria	Uncorrected hypokalemia or hypomagnesemia, long QT syndrome. Use of concomitant drugs known to prolong the QT interval or strong CYP3A4 inhibitors.
Required Medical Information	Patient (age 1 or older) has a diagnosis of newly diagnosed Philadelphia chromosome positive CML in chronic phase OR adult patient with a diagnosis of chronic phase or accelerated phase Philadelphia chromosome positive CML in patients that are resistant or intolerant to imatinib OR pediatric patient with a diagnosis of chronic phase Philadelphia chromosome positive CML in patients that are resistant or intolerant to prior tyrosine-kinase inhibitor therapy.
Age Restrictions	Age 1 and older for pediatric indications
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Tavalisse

Products Affected
- TAVALISSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of chronic immune thrombocytopenia (ITP). Patient had an insufficient response to a previous treatment.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Tazverik

Products Affected
- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of metastatic or locally advanced epithelioid sarcoma and is not eligible for complete resection. OR Patient has a diagnosis of relapsed or refractory follicular lymphoma with one of the following: tumors are positive for an EZH2 mutation and patient received at least 2 prior systemic therapies, or patient has no satisfactory alternative treatment options.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Tecfidera

Products Affected

- *dimethyl fumarate oral*
- TECFIDERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of a relapsing form of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. Patient must have a complete blood count within the past 6 months before initiation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	To continue therapy, the patient must demonstrate stabilization or improvement while on Tecfidera.
Indications	All FDA-approved Indications.
Off Label Uses	

Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Actively suicidal or has untreated or inadequately treated depression. Impaired hepatic function. Concomitant monoamine oxidase inhibitor (MAOI) or use within 14 days of stopping MAOI. Concomitant reserpine or use within 20 days of stopping reserpine.
Required Medical Information	Diagnosis of chorea associated with Huntington's disease. If treating for tardive dyskinesia, require failure of at least one previous therapy (e.g., amantadine, benzodiazepines, haloperidol, atypical antipsychotics, etc.) or Gilles de la Tourette's syndrome with failure or least one previous therapy (e.g., antipsychotic agents, clonidine). Patients who require doses greater than 50 mg/day will be genotyped for CYP2D6 to determine whether the patient is a poor, intermediate or extensive metabolizer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	For renewal, patient must have a lack of disease progression or have improvement in symptoms.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Tardive dyskinesia, Tourette's syndrome.

Thalomid

Products Affected
- THALOMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of: A) multiple myeloma that is newly diagnosed and is receiving concurrent dexamethasone B) acute treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum C) Maintenance therapy for prevention and suppression of the cutaneous manifestations of erythema nodosum leprosum recurrence. Thalidomide will not be used as monotherapy for erythema nodosum leprosum treatment if the member has moderate to severe neuritis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Tibsovo

Products Affected
- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of relapsed or refractory acute myeloid leukemia (AML) with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. OR Patient has a diagnosis of newly-diagnosed AML with a susceptible IDH1 mutation in a patient that is at least 75 years old or who has comorbidities that preclude the use of intensive induction chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Transmucosal Fentanyl Products

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has active cancer and TIRF will be used for breakthrough cancer pain. Patient has tried and failed or has contraindications to at least 2 of the following short acting narcotics: oxycodone, morphine sulphate, hydromorphone. Long-Acting opioid is being prescribed The patient is opioid tolerant (Patients are considered opioid tolerant if they have been taking at least 60 mg of oral morphine per day, 25 mcg of transdermal fentanyl/hr, 30 mg of oral oxycodone daily, 8 mg of oral hydromorphone daily, 25 mg oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer.).
Age Restrictions	16 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Trikafta

Products Affected
- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of cystic fibrosis and at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Tukysa

Products Affected
- TUKYSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has a diagnosis of advanced unresectable or metastatic breast cancer. Patient has HER2-positive disease and has received one or more prior anti-HER2-based regimen. Tukysa will be used in combination with trastuzumab and capecitabine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Turalio

Products Affected
- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of tenosynovial giant cell tumor (TGCT) and be symptomatic. Patients disease must be associated with severe morbidity or functional limitations and not be amenable to improvement with surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Tykerb

Products Affected
- TYKERB

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of advanced or metastatic breast cancer with overexpression of HER2 AND Tykerb will be used with capecitabine AND patient has received prior therapy with an anthracycline, a taxane, and trastuzumab. OR Patient is postmenopausal with a diagnosis of hormone receptor positive metastatic breast cancer with overexpression of HER2 AND Tykerb will be used with letrozole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Uptravi

Products Affected
- UPTRAVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group I) that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Venclexta

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	Must not be on a strong CYP3A inhibitor (such as ketoconazole, conivaptan, clarithromycin, indinavir, itraconazole, lopinavir, ritonavir, telaprevir, posaconazole, or voriconazole) at Venclexta initiation and during Venclexta ramp-up phase.
Required Medical Information	Patient has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). Patient has a diagnosis of newly-diagnosed acute myeloid leukemia (AML) in adults 75 or older or who have comorbidities that preclude the use of intensive induction chemotherapy AND Venclexta will be used in combination with azacitidine, or decitabine, or low-dose cytarabine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Verzenio

Products Affected
- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has advanced or metastatic hormone receptor (HR) positive, human epidermal growth factor receptor 2 (HER2) negative breast cancer. Patient will use in combination with an aromatase inhibitor as initial treatment in a post menopausal woman OR will be used in combination with fulvestrant in patients that had disease progression following endocrine therapy OR patient has metastatic disease and it will be used as monotherapy for patients that had disease progression following endocrine therapy and prior chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Viberzi

Products Affected
- VIBERZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of irritable bowel syndrome with diarrhea.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Vitrakvi

Products Affected
- VITRAKVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has solid tumors that have all of the following characteristics: a confirmed neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation, metastatic disease or where surgical resection is likely to result in severe morbidity, AND there are no satisfactory alternative treatments or disease has progressed following treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Vizimpro

Products Affected
- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations. Vizimpro will be used as a first-line treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Vosevi

Products Affected
- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Information required for review: genotype, prior HCV treatments, cirrhosis status (including Child-Pugh class), desired treatment regimen, viral load, HIV status, liver transplant history. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines with the highest evidence rating in that category as of the date of the request. In cases where the request is for a lower evidence rated treatment, an explanation will be required as to why the higher rated regimen is not preferred.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Votrient

Products Affected
- VOTRIENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of advanced renal cell carcinoma or advanced soft tissue sarcoma. Patients with a diagnosis of soft tissue sarcoma must have received prior chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Xalkori

Products Affected
- XALKORI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC). The tumor is ROS1- or ALK-positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Xgeva

Products Affected
- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multiple Myeloma (MM)/Bone metastasis from solid tumors (BMST): One of the following: 1) Diagnosis of multiple myeloma OR 2) diagnosis of solid tumors (eg, breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer), AND documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Both of the following: 1) diagnosis of giant cell tumor of bone AND 2) One of the following: a) tumor is unresectable, OR b) surgical resection is likely to result in severe morbidity. Hypercalcemia of malignancy (HCM): Both of the following: 1) diagnosis of hypercalcemia of malignancy, AND 2) Trial and failure, contraindication, or intolerance to one intravenous bisphosphonate (eg, pamidronate, Zometa (zoledronic acid).
Age Restrictions	
Prescriber Restrictions	GCTB, HCM: Prescribed by or in consultation with an oncologist
Coverage Duration	MM/BMST, GCTB: 12 mo. HCM: 2 mo.
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

Xolair

Products Affected

- XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of moderate or persistant asthma with base inadequate control on either inhaled corticosteroids and long acting beta agonist or inholed corticosteroids and long acting muscarinic antagonist or chronic idiopathic urticaria who remained symptomatic after previous trials of H1 antihistamines
Age Restrictions	Asthma age 6 and older, Chronic idiopathic Urticaria Age 12 and older
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Xospata

Products Affected
- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of relapsed or refractory acute myeloid leukemia (AML). Patient has a FMS-like tyrosine kinase 3 (FLT3) mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Xpovio

Products Affected

- XPOVIO (100 MG ONCE WEEKLY)
- XPOVIO (40 MG ONCE WEEKLY)
- XPOVIO (40 MG TWICE WEEKLY)
- XPOVIO (60 MG ONCE WEEKLY)
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY)
- XPOVIO (80 MG TWICE WEEKLY)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of relapsed or refractory multiple myeloma (RRMM) and meet the following criteria: received at least four prior therapies, disease must be refractory to at least two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody, and therapy must be used in combination with dexamethasone. OR Patient has a diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including arising from follicular lymphoma and must have tried at least 2 lines of systemic therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Xtandi

Products Affected
- XTANDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of castration-resistant prostate cancer (CRPC) or metastatic castration-sensitive prostate cancer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	For patients with metastatic, castration-resistant prostate cancer in patients who are not currently taking Xtandi, the patient must have had a trial with abiraterone (Zytiga) unless the patient is unable to try abiraterone.
Indications	All FDA-approved Indications.
Off Label Uses	

Xyrem

Products Affected
- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	Taking alcohol or sedative hypnotic agents while taking Xyrem.
Required Medical Information	Patient has a diagnosis of narcolepsy with either cataplexy or excessive daytime sleepiness. For patients with a diagnosis of excessive daytime sleepiness, patient has had a previous trial with or a contraindication, intolerance, or allergy to modafinil, armodafinil, methylphenidate, dextroamphetamine, or mixed amphetamine salts.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Yonsa

Products Affected
- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has metastatic castration-resistant prostate cancer. Yonsa will be used in combination with methylprednisolone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Zejula

Products Affected
- ZEJULA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of advanced or recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy. OR Patient has a diagnosis of advanced ovarian, fallopian tube, or primary peritoneal cancer who have been treated with 3 or more prior chemotherapy regimens AND the cancer is associated with homologous recombination deficiency (HRD) positive status defined by either a deleterious or suspected deleterious BRCA mutation or a genomic instability and who have progressed more than 6 months after response to the last platinum-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Zelboraf

Products Affected
- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of unresectable or metastatic melanoma and patient has positive BRAF-V600E mutation OR patient has a diagnosis of Erdheim-Chester Disease (ECD) with BRAF V600E mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Zepatier

Products Affected
- ZEPATIER

PA Criteria	Criteria Details
Exclusion Criteria	Patient has moderate or severe hepatic impairment (Child-Pugh B or C). Patient is on OATP1B1/3 inhibitors, strong inducers of CYP3A or efavirenz.
Required Medical Information	Information required for review: genotype, prior treatments, cirrhosis status, desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status, NS5A polymorphism status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines as of the date of the request.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 or 16 weeks per medical information provided
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Zolinza

Products Affected
- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of cutaneous T-cell lymphoma with progressive, persistent or recurrent disease. Patient has received at least two prior systemic therapies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Zydelig

Products Affected
- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For relapsed chronic lymphocytic leukemia, Zydelig is used in combination with rituximab. For relapsed follicular B-cell non-Hodgkin lymphoma and relapsed small lymphocytic lymphoma, patient has received at least two prior systemic therapies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Zykadia

Products Affected

- ZYKADIA
- ZYKADIA ORAL CAPSULE 150 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer and has anaplastic lymphoma kinase (ALK)-positive disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Index of Drugs