2027 Coverage Determination Criteria

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Prior Authorization Group Description

actimmune pa

Drug Name(s)

Actimmune

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

acyclovir topical pa

Drug Name(s)

Acyclovir Topical

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

aimovig pa

Drug Name(s)

Aimovig

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of migraine AND 2. The requested agent is being used for migraine prophylaxis AND 3. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of migraine AND 3. The requested agent is being used for migraine prophylaxis AND 4. Patient has had clinical benefit with the requested agent AND 5. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

alcohol swabs pa

Drug Name(s)

Alcohol Swabs

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

This program will be implemented as a dynamic PA. Criteria for approval require BOTH of the following: 1. The requested medical supply product will be used in the delivery of insulin to the body AND 2. Patient's medication history includes use of insulin within the past 180 days

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

alosetron pa

Drug Name(s)

Alosetron

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require ALL of the following: 1. Patient has a diagnosis of irritable bowel syndrome with severe diarrhea (IBS-D) AND 2. Patient's sex is female AND 3. Patient exhibits at least ONE of the following: a. Frequent and severe abdominal pain/discomfort OR b. Frequent bowel urgency or fecal incontinence OR c. Disability or restriction of daily activities due to IBS AND 4. Prescriber has ruled out anatomic or biochemical abnormalities of the gastrointestinal tract

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

alpha-1-proteinase inhibitor pa - prolastin-c

Drug Name(s)

Prolastin-C

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of alpha-1 antitrypsin deficiency (AATD) with clinically evident emphysema AND 2. Patient has a pre-treatment serum alpha-1 antitrypsin (AAT) level less than 11 micromol/L (80 mg/dL by immunodiffusion or 57 mg/dL using nephelometry) AND 3. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of alpha-1 antitrypsin deficiency (AATD) with clinically evident emphysema AND 3. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

anabolic steroid pa - danazol

Drug Name(s)

Danazol

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require BOTH of the following: 1. Patient has ONE of the following diagnoses: A. Patient has an FDA labeled indication for the requested agent OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR B. Prescriber has provided information in support of therapy with more than one agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

androgen injectable pa - testosterone cypionate

Drug Name(s)

Testosterone Cypionate

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require ALL of the following: 1. Patient has ONE of the following diagnoses: A. Patient's sex is male with AIDS/HIV-associated wasting syndrome with all other causes of weight loss have been ruled out OR B. Patient's sex is female with metastatic/inoperable breast cancer OR C. Patient's sex is male with primary or secondary (hypogonadotropic) hypogonadism OR D. Patient's sex is male and is an adolescent with delayed puberty AND 2. If the patient's sex is a male, ONE of the following: A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels: i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels: i. Total serum testosterone level that is within the testing laboratory's normal range OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR ii. Free serum testosterone level is within the testing laboratory's normal range OR below the testing laboratory's normal range AND 3. ONE of the following: A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR B. Prescriber has provided information in support of therapy with more than one agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

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

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

androgen injectable pa - testosterone enanthate

Drug Name(s)

Testosterone Enanthate

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require ALL of the following: 1. Patient has ONE of the following diagnoses: A. Patient's sex is male with AIDS/HIV-associated wasting syndrome with all other causes of weight loss have been ruled out OR B. Patient's sex is female with metastatic/inoperable breast cancer OR C. Patient's sex is male with primary or secondary (hypogonadotropic) hypogonadism OR D. Patient's sex is male and is an adolescent with delayed puberty AND 2. If the patient's sex is a male, ONE of the following: A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels: i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels: i. Total serum testosterone level that is within the testing laboratory's normal range OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR ii. Free serum testosterone level is within the testing laboratory's normal range OR below the testing laboratory's normal range AND 3. ONE of the following: A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR B. Prescriber has provided information in support of therapy with more than one agent If the patient's sex is a male, ONE of the following: A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels: i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels: i. Total serum testosterone level that is within the testing laboratory's normal range OR below the

testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR ii. Free serum testosterone level is within the testing laboratory's normal range OR below the testing laboratory's normal range AND 3. ONE of the following: A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR B. Prescriber has provided information in support of therapy with more than one agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

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

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

androgen topical pa

Drug Name(s)

Androgren Topical

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require ALL of the following: 1. Patient has ONE of the following diagnoses: A. Patient has AIDS/HIV-associated wasting syndrome with all other causes of weight loss have been ruled out OR B. Patient's sex is male with primary or secondary (hypogonadotropic) hypogonadism AND 2. If the patient's sex is male, ONE of the following: A. Patient is NOT currently receiving testosterone replacement therapy AND has ONE of the following pretreatment levels: i. Total serum testosterone level that is below the testing laboratory's lower limit of the normal range or is less than 300 ng/dL OR ii. Free serum testosterone level that is below the testing laboratory's lower limit of the normal range OR B. Patient is currently receiving testosterone replacement therapy AND has ONE of the following current levels: i. Total serum testosterone level that is within the testing laboratory's normal range OR below the testing laboratory's lower limit of the normal range OR is less than 300 ng/dL OR ii. Free serum testosterone level is within the testing laboratory's normal range OR below the testing laboratory's normal range AND 3. ONE of the following: A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR B. Prescriber has submitted information in support of therapy with more than one agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa - chlorpromazine

Drug Name(s)

Chlorpromazine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa -clozapine

Drug Name(s)

Clozapine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa fanapt

Drug Name(s)

Fanapt

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa -fluphenazine

Drug Name(s)

Fluphenazine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa haldol

Drug Name(s)

Haldol

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa -loxapine

Drug Name(s)

Loxapine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa -lurasidone

Drug Name(s)

Lurasidone

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa -lybalvi

Drug Name(s)

Lybalvi

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa -molindone

Drug Name(s)

Molindone

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa -olanzapine

Drug Name(s)

Olanzapine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa -opiza

Drug Name(s)

Opiza

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa -paliperidone

Drug Name(s)

Paliperidone

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa -perphenazine

Drug Name(s)

Perphanazine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa -pimozide

Drug Name(s)

Pimozide

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa- quetiapine

Drug Name(s)

Quetiapine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa -rexulti

Drug Name(s)

Rexulti

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa -secuado

Drug Name(s)

Secuado

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa- thioridazine

Drug Name(s)

Thioridazine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa- thiothixene

Drug Name(s)

Thiothixene

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa- triflourperazine

Drug Name(s)

Triflourperazine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa- zisprasidone

Drug Name(s)

Zisprasidone

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

antipsychotics pa-risperadone

Drug Name(s)

Risperadone

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent OR c. ONE of the following: i. Patient has a diagnosis other than dementia-related psychosis or dementia related behavioral symptoms OR ii. Patient has dementia-related psychosis or dementia related behavioral symptoms AND BOTH of the following: 1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND 2. Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

apomorphine inj pa

Drug Name(s)

Apomorphine

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require ALL of the following: 1. The requested agent will be used to treat acute, intermittent hypomobility, off episodes (end of dose wearing off and unpredictable on/off episodes) associated with advanced Parkinson's disease AND 2. The requested agent will be used in combination with agents used for therapy in Parkinson's disease (e.g., levodopa, dopamine agonist, monoamine oxidase B inhibitor) AND 3. Patient will NOT be using the requested agent in combination with a 5-HT3 antagonist (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron)

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

arcalyst pa

Drug Name(s)

Arcalyst

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require BOTH of the following: 1. ONE of the following: A. Patient has been diagnosed with Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Auto-inflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS) OR B. BOTH of the following: i. Patient has a diagnosis of deficiency of interleukin-1 receptor antagonist AND ii. The requested agent is being used for maintenance of remission OR C. BOTH of the following: i. Patient has a diagnosis of recurrent pericarditis AND ii. The requested agent is being used to reduce the risk of recurrence AND 2. Patient will NOT be using the requested agent in combination with another biologic agent

Age Restrictions:

for diagnosis of caps including fcas or mws, patient is 12 years of age or over for diagnosis of recurrent pericarditis and reduction in risk of recurrence, patient is 12 years of age or over

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

arikayce pa

Drug Name(s)

Arikayce

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

armodafinil pa

Drug Name(s)

Armodafinil

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another target agent (i.e., modafinil)

Age Restrictions:

patient is 17 years of age or over

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

atopic dermatitis pa - tacrolimus

Drug Name(s)

Tacrolimus

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

atovaquone pa

Drug Name(s)

Atovaquone

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: 1. Patient has a diagnosis of mild-to-moderate Pneumocystis jirovecii pneumonia OR 2. Patient is using the requested agent for prevention of Pneumocystis jirovecii pneumonia AND ii. ONE of the following: 1. Patient has an intolerance or hypersensitivity to trimethoprim/sulfamethoxazole (TMP/SMX) OR 2. Patient has an FDA labeled contraindication to trimethoprim/sulfamethoxazole (TMP/SMX) OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

austedo pa

Drug Name(s)

Austedo

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require ALL of the following: 1. ONE of the following: A. Patient has a diagnosis of chorea associated with Huntington's disease AND BOTH of the following: i. ONE of the following: 1. Patient does NOT have a current diagnosis of depression OR 2. Patient has a current diagnosis of depression and is being treated for depression AND ii. ONE of the following: 1. Patient does NOT have a diagnosis of passive suicidal ideation, behavior, or both OR 2. Patient has a diagnosis of passive suicidal ideation, behavior, or both and must NOT be actively suicidal OR B. Patient has a diagnosis of tardive dyskinesia AND ONE of the following: i. Prescriber has reduced the dose of or discontinued any medications known to cause tardive dyskinesia (i.e., dopamine receptor blocking agents) OR ii. Prescriber has provided clinical rationale indicating that a reduced dose or discontinuation of any medications known to cause tardive dyskinesia is not appropriate AND 2. Patient will NOT be using the requested agent in combination with a monoamine oxidase inhibitor (MAOI) AND 3. Patient will NOT be using the requested agent in combination with reserpine

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

benign prostatic hyperplasia pa - tadalafil

Drug Name(s)

Tadalafil

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

benlysta sc pa

Drug Name(s)

Benlysta SC

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. ONE of the following: a. Patient has a diagnosis of active systemic lupus erythematosus (SLE) disease AND the following: i. Patient will continue standard SLE therapy [corticosteroids (e.g., methylprednisolone, prednisone), hydroxychloroquine, immunosuppressives (e.g., azathioprine, methotrexate, oral cyclophosphamide)] in combination with the requested agent OR b. Patient has a diagnosis of active lupus nephritis (LN) AND the following: i. Patient will continue standard LN therapy [corticosteroids (e.g., methylprednisolone, prednisone), immunosuppressives (e.g., azathioprine, mycophenolate)] in combination with the requested agent AND 2. Patient will NOT be using the requested agent in combination with another biologic agent AND 3. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: a. Patient has diagnosis of active systemic lupus erythematosus (SLE) disease AND the following: i. Patient will continue standard SLE therapy [corticosteroids (e.g., methylprednisolone, prednisone), hydroxychloroquine, immunosuppressives (e.g., azathioprine, methotrexate, oral cyclophosphamide)] in combination with the requested agent OR b. Patient has a diagnosis of active lupus nephritis (LN) AND the following: i. Patient will continue standard LN therapy [corticosteroids (e.g., methylprednisolone, prednisone), immunosuppressives (e.g., azathioprine, mycophenolate)] in combination with the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another biologic agent AND 5. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

patient is 5 years of age or over

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

benzodiazepines pa - clobazam

Drug Name(s)

Clobazam

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. BOTH of the following: i. Patient has ONE of the following diagnoses: a. Seizure disorder OR b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

benzodiazepines pa - clorazepate

Drug Name(s)

Clorazepate

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. BOTH of the following: i. Patient has ONE of the following diagnoses: a. Seizure disorder OR b. Anxiety disorder AND ONE of the following: 1) Patient has tried and has an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR 2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR 3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR c. Alcohol withdrawal OR d. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

benzodiazepines pa - diazepam

Drug Name(s)

Diazepam

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. BOTH of the following: i. Patient has ONE of the following diagnoses: a. Seizure disorder OR b. Anxiety disorder AND ONE of the following: 1) Patient has tried and had an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR 2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR 3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR c. Skeletal muscle spasms OR d. Alcohol withdrawal OR e. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

benzodiazepines pa - lorazepam

Drug Name(s)

Lorazepam

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. BOTH of the following: i. Patient has ONE of the following diagnoses: a. Anxiety disorder AND ONE of the following: 1) Patient has tried and had an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR 2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR 3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

benzodiazepines pa - sympazan

Drug Name(s)

Sympazan

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. BOTH of the following: i. Patient has ONE of the following diagnoses: a. Seizure disorder OR b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

bexarotene gel pa

Drug Name(s)

Bexarotene Gel

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. ALL of the following: i. ONE of the following: 1. BOTH of the following: a. Patient has a diagnosis of stage IA or IB cutaneous T-cell lymphoma (CTCL) with cutaneous lesions AND b. ONE of the following: i. Patient has refractory or persistent disease despite a previous treatment trial with a skin-directed therapy (e.g., topical corticosteroid, topical imiquimod) OR ii. Patient has an intolerance or hypersensitivity to a previous treatment trial with a skin-directed therapy (e.g., topical corticosteroid, topical imiquimod) OR iii. Patient has an FDA labeled contraindication to a previous treatment trial with a skin-directed therapy (e.g., topical corticosteroid, topical imiquimod) OR 2. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist, oncologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND iii. Patient does NOT have any FDA labeled contraindications to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

biologic immunomodulators pa - actemra

Drug Name(s)

Actemra

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 4. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity, frequency, or both) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 5. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

biologic immunomodulators pa - cosentyx

Drug Name(s)

Cosentyx

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity, frequency, or both) AND 4. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Use of ONE conventional prerequisite agent is required for diagnoses of plaque psoriasis NO prerequisites are required for diagnoses of ankylosing spondylitis, enthesitis related arthritis, hidradenitis suppurativa, or non-radiographic axial spondyloarth

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

biologic immunomodulators pa - enbrel

Drug Name(s)

Enbrel

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 4. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity, frequency, or both) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 5. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Use of ONE conventional prerequisite agent is required for diagnoses of plaque psoriasis, rheumatoid arthritis, juvenile psoriatic arthritis, or juvenile idiopathic arthritis NO prerequisites are required for a diagnoses of ankylosing spondylitis or seve

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

biologic immunomodulators pa - entyvio sc

Drug Name(s)

Entyvio SC

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 4. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity, frequency, or both) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 5. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Use of ONE conventional prerequisite agent is required for diagnoses of Crohn's disease, plaque psoriasis, or psoriatic arthritis Non-biologic therapy is not required for moderately to severely active Crohn's disease or moderate ulcerative colitis Formul

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

biologic immunomodulators pa - hadlima

Drug Name(s)

Hadlima

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 4. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity, frequency, or both) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 5. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be 12 weeks for initial use for ulcerative colitis, 12 months for all others. Reauthorization will be 12 months for ulcerative colitis and all others

Other Criteria:

Use of ONE conventional prerequisite agent is required for diagnoses of plaque psoriasis, rheumatoid arthritis, juvenile idiopathic arthritis, Crohn's disease, or moderate ulcerative colitis NO prerequisites are required for diagnoses of ankylosing spond

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

biologic immunomodulators pa - orencia

Drug Name(s)

Orencia

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. ONE of the following: i. Patient's diagnosis is indicated for preferred biologic immunomodulator agent(s) AND ONE of the following: a. Patient's medication history indicates use of preferred biologic immunomodulator agent(s) OR b. Patient has an intolerance or hypersensitivity to preferred biologic immunomodulator agent(s) OR c. Patient has an FDA labeled contraindication to preferred biologic immunomodulator agent(s) OR ii. The request is for an FDA labeled indication that is not covered by preferred biologic immunomodulator agent(s) AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 4. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 5. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Use of TWO preferred agents (Enbrel, Hadlima, Rinvoq tablets, or Rinvoq solution) is required for diagnosis of juvenile idiopathic arthritis Use of TWO preferred agents (Enbrel, Hadlima, or Rinvoq tablets) is required for diagnosis of rheumatoid arthritis

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

biologic immunomodulators pa - rinvoq

Drug Name(s)

Rinvoq

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. ONE of the following: i. BOTH of the following: a. Patient has an FDA labeled indication other than moderate to severe atopic dermatitis for the requested agent AND b. ONE of the following: 1. Patient's medication history indicates use of preferred TNF agent(s) OR 2. Patient has an intolerance or hypersensitivity to preferred TNF agent(s) OR 3. Patient has an FDA labeled contraindication to preferred TNF agent(s) OR 4. The request is for an FDA labeled indication that is not covered by preferred TNF agent(s) OR ii. Patient has a diagnosis of moderate to severe atopic dermatitis AND ONE of the following: a. Patient's medication history indicates use of ONE formulary topical calcineurin inhibitor for the requested indication OR b. Patient has an intolerance or hypersensitivity to ONE formulary topical calcineurin inhibitor) for the requested indication OR c. Patient has an FDA labeled contraindication to ONE formulary topical calcineurin inhibitor) for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 4. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

biologic immunomodulators pa - simlandi

Drug Name(s)

Simlandi

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 4. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity, frequency, or both) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 5. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Use of ONE conventional prerequisite agent is required for diagnoses of Crohn's disease or plaque psoriasis Non-biologic therapy is not required for moderately to severely active Crohn's disease or moderate ulcerative colitis Formulary conventional agents

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

biologic immunomodulators pa - skyrizi

Drug Name(s)

Skyrizi

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR E. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity, frequency, or both) AND 4. The requested dose is within FDA labeled dosing for the requested indicationCriteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's

medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR E. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 4. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 5. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Use of ONE conventional prerequisite agent is required for diagnoses of Crohn's disease or plaque psoriasis Non-biologic therapy is not required for moderately to severely active Crohn's disease or moderate ulcerative colitis Formulary conventional agents

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

biologic immunomodulators pa - stelara

Drug Name(s)

Stelara

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity, frequency, or both) AND 4. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Use of ONE conventional prerequisite agent is required for diagnoses of plaque psoriasis, moderate ulcerative colitis, or Crohn's disease Non-biologic therapy is not required for moderately to severely active Crohn's disease or moderate ulcerative coliti

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

biologic immunomodulators pa - steqeyma

Drug Name(s)

Steqeyma

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity, frequency, or both) AND 4. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Use of ONE conventional prerequisite agent is required for diagnoses of Crohn's disease, or plaque psoriasis Non-biologic therapy is not required for moderately to severely active Crohn's disease or moderate ulcerative colitis Formulary conventional age

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

biologic immunomodulators pa - tremfya

Drug Name(s)

Tremfya

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR E. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity, frequency, or both) AND 4. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Use of ONE conventional prerequisite agent is required for diagnoses of psoriatic arthritis or plaque psoriasis Formulary conventional agents (topical or systemic) for plaque psoriasis include acitretin, calcipotriene, methotrexate, tazarotene, or topica

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

biologic immunomodulators pa - tyenne

Drug Name(s)

Tyenne

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR E. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 4. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity, frequency, or both) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator AND 5. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

bivigam/flebogamma/gammaplex/octagam/privigen pa

Drug Name(s)

Bivigam/Flebogamma/Gammaplex/Octagam/Privigen

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 6 months for indications in Other Criteria, 12 months for all others

Other Criteria:

G. Myasthenia gravis (MG) AND ONE of the following: i. Patient is in acute myasthenic crisis OR ii. Patient has severe refractory MG (e.g., major functional disability/weakness) AND ONE of the following: a) Patient has failed ONE immunomodulator therapy (

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

budesonide oral er pa - entocort

Drug Name(s)

Entocort

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

budesonide oral er pa - uceris

Drug Name(s)

Uceris

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

carglumic pa

Drug Name(s)

Carglumic

Indications:

Off-Label Uses:

Acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA)

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist, nephrologist, metabolic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

cayston pa

Drug Name(s)

Cayston

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

cinacalcet pa

Drug Name(s)

Cinacalcet

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. Patient has ONE of the following: A. A diagnosis of hypercalcemia due to parathyroid carcinoma OR B. A diagnosis of primary hyperparathyroidism (HPT) AND BOTH of the following: i. Patient has a pretreatment serum calcium level that is above the testing laboratory's upper limit of normal AND ii. Patient is unable to undergo parathyroidectomy OR C. Another indication that is FDA approved or supported in CMS approved compendia for the requested agent not otherwise excluded from Part D [i.e., secondary hyperparathyroidism due to end-stage renal disease (ESRD) on dialysis]

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

cobenfy pa

Drug Name(s)

Cobenfy

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR b. Prescriber states the patient is currently being treated with the requested agent AND Prescriber has documented that s/he has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker Approval authorizations will apply to the requested medication only.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

colony stimulating factors pa - granix

Drug Name(s)

Granix

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 6 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

colony stimulating factors pa - leukine

Drug Name(s)

Leukine

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 6 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

corlanor pa

Drug Name(s)

Corlanor

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

cresemba pa

Drug Name(s)

Cresemba

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 6 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

cystadrops pa

Drug Name(s)

Cystadrops

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., ophthalmologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

cystaran pa

Drug Name(s)

Cystaran

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., ophthalmologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

cystinosis agents pa - cystagon

Drug Name(s)

Cystagon

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of nephropathic cystinosis AND 2. Prescriber has performed a baseline white blood cell (WBC) cystine level test AND 3. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of nephropathic cystinosis AND 3. Patient has had clinical benefit with the requested agent (e.g., decrease in WBC cystine levels from baseline) AND 4. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

dalfampridine pa

Drug Name(s)

Dalfampridine

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. Patient has a diagnosis of multiple sclerosis (MS) AND 2. ONE of the following: A. The requested agent will be used in combination with a disease modifying agent [e.g., dimethyl fumarate, glatiramer (e.g., Copaxone)] OR B. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to a disease modifying agent OR C. Prescriber has provided information indicating that a disease modifying agent is not clinically appropriate for the patient Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of multiple sclerosis (MS) AND 3. ONE of the following: A. The requested agent will be used in combination with a disease modifying agent [e.g., dimethyl fumarate, glatiramer (e.g., Copaxone)] OR B. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to a disease modifying agent OR C. Prescriber has provided information indicating that a disease modifying agent is not clinically appropriate for the patient AND 4. Patient has had improvements or stabilization from baseline in timed walking speed (timed 25-foot walk)

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Initial approval will be for 4 months, renewal approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

droxidopa pa

Drug Name(s)

Droxidopa

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of neurogenic orthostatic hypotension (nOH) AND 2. Prescriber has performed baseline blood pressure readings while the patient is sitting, supine (lying face up), or by tilt table testing AND 3. Patient has a decrease of at least 20 mmHg in systolic blood pressure or 10 mmHg diastolic blood pressure within three minutes after standing AND 4. Patient has persistent and consistent symptoms of neurogenic orthostatic hypotension (nOH) caused by ONE of the following: A. Primary autonomic failure [Parkinson's disease (PD), multiple system atrophy, or pure autonomic failure] OR B. Dopamine beta-hydroxylase deficiency OR C. Non-diabetic autonomic neuropathy AND 5. Prescriber has assessed the severity of the patient's baseline symptoms of dizziness, lightheadedness, feeling faint, or feeling like the patient may black out AND 6. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of neurogenic orthostatic hypotension (nOH) AND 3. Patient has had improvements or stabilization with the requested agent as indicated by improvement in severity from baseline symptoms of ONE of the following: A. Dizziness B. Lightheadedness C. Feeling faint D. Feeling like the patient may black out AND 4. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist, neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be 1 month for initial, 3 months for renewal

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

dupixent pa

Drug Name(s)

Dupixent

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. ONE of the following: A. Patient has a diagnosis of moderate-to-severe atopic dermatitis AND ALL of the following: i. For patients 2 years of age or over, ONE of the following: a. Patient has tried and failed a topical calcineurin inhibitor (e.g., tacrolimus) OR b. Patient has an intolerance, hypersensitivity, or an FDA labeled contraindication to a topical calcineurin inhibitor AND ii. Patient will NOT be using the requested agent in combination with another biologic agent for the requested indication OR B. Patient has a diagnosis of moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid dependent asthma AND BOTH of the following: i. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LRTA, LAMA, theophylline) in combination with the requested agent AND ii. Patient will NOT be using the requested agent in combination with Xolair or with an injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Fasenra, Nucala) for the requested indication OR C. Patient has a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) AND the following: i. BOTH of the following: a. ONE of the following: 1. Patient has tried and had an inadequate response to an oral systemic corticosteroid AND an intranasal corticosteroid (e.g., fluticasone) OR 2. Patient has an intolerance, hypersensitivity, or an FDA labeled contraindication to an oral systemic corticosteroid AND an intranasal corticosteroid AND Initial criteria continues: see Other Criteria

Age Restrictions:

for diagnosis of moderate-to-severe atopic dermatitis, patient is 6 months of age or over. for diagnosis of moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid dependent asthma, patient is 6 years of age or over. for diagnosis

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, dermatologist, immunologist, gastroenterologist, otolaryngologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

b. Patient will continue standard maintenance therapy (e.g., intranasal corticosteroid) in combination with the requested agent OR D. Patient has a diagnosis of eosinophilic esophagitis (EoE) confirmed by esophageal biopsy OR E. Patient has a diagnosis of

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

emgality pa

Drug Name(s)

Emgality

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of migraine AND ALL of the following: i. The requested agent is being used for migraine prophylaxis AND ii. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis OR B. Patient has a diagnosis of episodic cluster headache AND BOTH of the following: i. Patient has had cluster headache attacks AND ii. Patient has had cluster periods lasting 7 days to one year and separated by pain-free remission periods of 3 months or more Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. ALL of the following: i. Patient has a diagnosis of migraine AND ii. The requested agent is being used for migraine prophylaxis AND iii. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis OR B. Patient has a diagnosis of episodic cluster headache AND 3. Patient has had clinical benefit with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

emsam pa

Drug Name(s)

Emsam

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. ONE of the following: A. Patient has a diagnosis of major depressive disorder (MDD) OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. BOTH of the following: i. ONE of the following: a. BOTH of the following: i. Patient has a diagnosis of major depressive disorder (MDD) AND ii. ONE of the following: 1. Patient has tried and had an inadequate response to at least two different oral antidepressants (e.g., SSRIs, SNRIs, mirtazapine, bupropion) OR 2. Patient has an intolerance or hypersensitivity to at least two different oral antidepressants (e.g., SSRIs, SNRIs, mirtazapine, bupropion) OR 3. Patient has an FDA labeled contraindication to at least two different oral antidepressants (e.g., SSRIs, SNRIs, mirtazapine, bupropion) OR b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

endari pa

Drug Name(s)

Endari

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of sickle cell disease AND 2. Patient is using the requested agent to reduce the acute complications of sickle cell disease AND 3. ONE of the following: A. Patient has tried and had an inadequate response to maximally tolerated dose of hydroxyurea OR B. Patient has an intolerance or hypersensitivity to hydroxyurea OR C. Patient has an FDA labeled contraindication to hydroxyurea AND 4. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of sickle cell disease AND 3. Patient is using the requested agent to reduce the acute complications of sickle cell disease AND 4. Patient has had clinical benefit with the requested agent AND 5. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

patient is within the fda labeled age for the requested agent

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

epidiolex pa

Drug Name(s)

Epidiolex

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require BOTH of the following: 1. Patient has a diagnosis of seizures associated with ONE of the following: A. Lennox-Gastaut syndrome OR B. Dravet syndrome OR C. Tuberous sclerosis complex AND 2. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

patient is within the fda labeled age for the requested agent

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

erythropoietin stimulating agents pa - epogen/procrit

Drug Name(s)

Epogen/Procrit

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require BOTH of the following: 1. The requested agent is being prescribed for ONE of the following: A. To reduce the possibility of allogeneic blood transfusion in a surgery patient AND the patient's hemoglobin level is greater than 10 g/dL but less than or equal to 13 g/dL OR B. Anemia due to myelosuppressive chemotherapy for a non-myeloid malignancy AND ALL of the following: i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR less than 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND ii. Patient is being concurrently treated with chemotherapy with or without radiation (there must be a minimum of 2 additional months of planned chemotherapy) AND iii. The intent of chemotherapy is non-curative OR C. Anemia associated with chronic kidney disease in a patient NOT on dialysis AND ALL of the following: i. Patient's hemoglobin level is less than 11.5 g/dL for patients initiating ESA therapy OR for patients stabilized on therapy (measured within the previous 4 weeks) AND ii. The rate of hemoglobin decline indicates the likelihood of requiring a RBC transfusion AND iii. The intent of therapy is to reduce the risk of alloimmunization and/or other RBC transfusion related risks OR D. Anemia due to myelodysplastic syndrome AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) OR E. Anemia resulting from zidovudine treatment of HIV infection AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) OR Initial criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

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

Other Criteria:

F. Another indication that is supported in CMS approved compendia for the requested agent AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR for patients stabilized on therapy AND 2. Patient's transferrin satura

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

erythropoietin stimulating agents pa - retacrit

Drug Name(s)

Retacrit

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require BOTH of the following: 1. The requested agent is being prescribed for ONE of the following: A. To reduce the possibility of allogeneic blood transfusion in a surgery patient AND the patient's hemoglobin level is greater than 10 g/dL but less than or equal to 13 g/dL OR B. Anemia due to myelosuppressive chemotherapy for a non-myeloid malignancy AND ALL of the following: i. Patient's hemoglobin level is less than 10 g/dL for patients initiating ESA therapy OR less than 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND ii. Patient is being concurrently treated with chemotherapy with or without radiation (there must be a minimum of 2 additional months of planned chemotherapy) AND iii. The intent of chemotherapy is non-curative OR C. Anemia associated with chronic kidney disease in a patient NOT on dialysis AND ALL of the following: i. Patient's hemoglobin level is less than 11.5 g/dL for patients initiating ESA therapy OR for patients stabilized on therapy (measured within the previous 4 weeks) AND ii. The rate of hemoglobin decline indicates the likelihood of requiring a RBC transfusion AND iii. The intent of therapy is to reduce the risk of alloimmunization and/or other RBC transfusion related risks OR D. Anemia resulting from zidovudine treatment of HIV infection AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) OR E. Another indication that is supported in CMS approved compendia for the requested agent AND the patient's hemoglobin level is less than 12 g/dL for patients initiating ESA therapy OR less than or equal to 12 g/dL for patients stabilized on therapy (measured within the previous 4 weeks) AND 2. Patient's transferrin saturation and serum ferritin have been evaluated Drug is also subject to Part B versus Part D review.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

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

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

fintepla pa

Drug Name(s)

Fintepla

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require BOTH of the following: 1. Patient has a diagnosis of seizures associated with Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS) AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. ALL of the following: i. An echocardiogram assessment will be obtained before and during treatment with the requested agent, to evaluate for valvular heart disease and pulmonary arterial hypertension AND ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND iii. Patient does NOT have any FDA labeled contraindications to the requested agent

Age Restrictions:

patient is within the fda labeled age for the requested agent

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

flucytosine pa

Drug Name(s)

Flucytosine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. The requested agent will be used in combination with amphotericin B OR B. Prescriber has provided information in support of therapy without concurrent amphotericin B for the requested indication AND 3. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 10 weeks

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

focalin pa

Drug Name(s)

Focalin

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

gammagard/gammaked/gamunex-c pa

Drug Name(s)

Gammagard/Gammaked/Gamunex-C

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 6 months for indications in Other Criteria, 12 months for all others

Other Criteria:

G. Myasthenia gravis (MG) AND ONE of the following: i. Patient is in acute myasthenic crisis OR ii. Patient has severe refractory MG (e.g., major functional disability/weakness) AND ONE of the following: a) Patient has failed ONE immunomodulator therapy (

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

gattex pa

Drug Name(s)

Gattex

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of short bowel syndrome (SBS) AND 2. Patient is dependent on parenteral nutrition OR intravenous (PN/IV) fluids AND 3. ONE of the following: A. Patient is aged 1 year to 17 years AND BOTH of the following: i. A fecal occult blood test has been performed within 6 months prior to initiating treatment with the requested agent AND ii. ONE of the following: a. There was no unexplained blood in the stool OR b. There was unexplained blood in the stool AND a colonoscopy or a sigmoidoscopy was performed OR B. Patient is 18 years of age or over AND BOTH of the following: i. Patient has had a colonoscopy within 6 months prior to initiating treatment with the requested agent AND ii. If polyps were present at this colonoscopy, the polyps were removed AND 4. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of short bowel syndrome (SBS) AND 3. Patient has had a reduction from baseline in parenteral nutrition OR intravenous (PN/IV) fluids AND 4. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be 6 months for initial, 12 months for renewal

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

gauze pads pa

Drug Name(s)

Gauze Pads

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

This program will be implemented as a dynamic PA. Criteria for approval require BOTH of the following: 1. The requested medical supply product will be used in the delivery of insulin to the body AND 2. Patient's medication history includes use of insulin within the past 180 days

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

growth hormone pa - omnitrope

Drug Name(s)

Omnitrope

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

For Children - Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of Turner Syndrome OR B. Patient has a diagnosis of Prader-Willi Syndrome OR C. Patient has a diagnosis of panhypopituitarism AND BOTH of the following: i. Deficiencies in 3 or more pituitary axes AND ii. Measured serum IGF-1 (insulin-like growth factor-1) levels are below the age and sex-appropriate reference range when off GH therapy OR D. Patient has a diagnosis of growth hormone deficiency (GHD) or short stature AND Failure of at least 2 growth hormone (GH) stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab) OR E. Patient has a diagnosis of small for gestational age (SGA) AND ALL of the following: i. Patient is at least 2 years of age AND ii. Documented birth weight and/or length that is 2 or more SD below the mean for gestational age AND iii. At 24 months of age, the patient fails to manifest catch-up growth evidenced by a height that remains 2 or more SD below the mean for age and sex

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

For Children - Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the preferred agent through the plan's Prior Authorization criteria AND 2. Patient has been diagnosed with ONE of the following: A. Grow

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

hae pa - cinryze

Drug Name(s)

Cinryze

Indications:

All FDA-approved indications plus some medically accepted indications

Off-Label Uses:

Acute HAE attacks

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed via two confirmatory tests of C1-INH antigenic level, C1-INH functional level, and C4 level AND ONE of the following: i. BOTH of the following: 1. Family history of angioedema AND 2. ALL other causes of angioedema have been ruled out OR ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, plasminogen (PLG) mutation, kininogen1 mutation, heparan sulfate 3-O-sulfotransferase 6 gene mutation, or myoferlin gene mutation that is associated with the disease AND 2. Medications known to cause angioedema (e.g., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND 3. ONE of the following: a. The requested agent will be used to treat acute HAE attacks AND the patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks OR b. The requested agent will be used for prophylaxis against HAE attacks AND the patient will NOT be using the requested agent in combination with another HAE agent indicated for prophylaxis against HAE attacks

Age Restrictions:

patient is within the fda labeled age for the requested agent

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of hereditary angioedema (HAE) AND ONE of the follow

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

hae pa - haegarda

Drug Name(s)

Haegarda

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed via two confirmatory tests of C1-INH antigenic level, C1-INH functional level, and C4 level AND ONE of the following: i. BOTH of the following: 1. Family history of angioedema AND 2. ALL other causes of angioedema have been ruled out OR ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, plasminogen (PLG) mutation, kininogen1 mutation, heparan sulfate 3-O-sulfotransferase 6 gene mutation, or myoferlin gene mutation that is associated with the disease AND 2. Medications known to cause angioedema (e.g., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND 3. The requested agent will be used for prophylaxis against HAE attacks AND 4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for prophylaxis against HAE attacks

Age Restrictions:

patient is within the fda labeled age for the requested agent

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of hereditary angioedema (HAE) AND 3. The requested

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

hae pa - icatibant

Drug Name(s)

Icatibant

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of hereditary angioedema (HAE) which has been confirmed via two confirmatory tests of C1-INH antigenic level, C1-INH functional level, and C4 level AND ONE of the following: i. BOTH of the following: 1. Family history of angioedema AND 2. ALL other causes of angioedema have been ruled out OR ii. Patient demonstrates a Factor XII mutation, angiopoietin-1 (ANGPT1) mutation, plasminogen (PLG) mutation, kininogen1 mutation, heparan sulfate 3-O-sulfotransferase 6 gene mutation, or myoferlin gene mutation that is associated with the disease AND 2. Medications known to cause angioedema (e.g., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate AND 3. The requested agent will be used to treat acute HAE attacks AND 4. Patient will NOT be using the requested agent in combination with another HAE agent indicated for treatment of acute HAE attacks

Age Restrictions:

patient is within the fda labeled age for the requested agent

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of hereditary angioedema (HAE) AND 3. The requested

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

high risk medication pa - all starts - benztrop

Drug Name(s)

Bentrop

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND 2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND 3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

high risk medication pa - all starts- atarax

Drug Name(s)

Atarax

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND 2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND 3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

high risk medication pa - all starts -bentyl

Drug Name(s)

Bentyl

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND 2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND 3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

high risk medication pa - all starts -benztrop

Drug Name(s)

Benztrop

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND 2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND 3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

high risk medication pa - all starts -periactin

Drug Name(s)

Periactin

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND 2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND 3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

high risk medication pa - all starts- promethazine

Drug Name(s)

Promethazine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND 2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND 3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

high risk medication pa - all starts-lomotil

Drug Name(s)

Lomotil

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND 2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND 3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

high risk medication pa - all starts-scopolamine

Drug Name(s)

Scopolamine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients less than 65 years of age. Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND 2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND 3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

imiquimod pa

Drug Name(s)

Imiquimod

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. Patient has ONE of the following diagnoses: A. Actinic keratosis OR B. Superficial basal cell carcinoma OR C. External genital and/or perianal warts/condyloma acuminata OR D. Squamous cell carcinoma OR E. Basal cell carcinoma OR F. Another indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

4 months for Actinic keratosis, other diagnoses - see Other Criteria

Other Criteria:

2 months for Superficial basal cell carcinoma, Squamous cell carcinoma, or Basal cell carcinoma 4 months for External genital and/or perianal warts/condyloma acuminata 12 months for All other diagnoses

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

inbrija pa

Drug Name(s)

Inbrija

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require BOTH of the following: 1. The requested agent will be used for intermittent treatment of OFF episodes in patients with Parkinson's disease AND 2. The requested agent will be used in combination with carbidopa/levodopa

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ingrezza pa

Drug Name(s)

Ingrezza

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

insulin pen needle pa

Drug Name(s)

Insulin Pen Needle

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

This program will be implemented as a dynamic PA. Criteria for approval require BOTH of the following: 1. The requested medical supply product will be used in the delivery of insulin to the body AND 2. Patient's medication history includes use of insulin within the past 180 days

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

insulin syringe_needle pa

Drug Name(s)

Insulin Syringe Needle

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

This program will be implemented as a dynamic PA. Criteria for approval require BOTH of the following: 1. The requested medical supply product will be used in the delivery of insulin to the body AND 2. Patient's medication history includes use of insulin within the past 180 days

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

iron chelating agents pa - exjade

Drug Name(s)

Exjade

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. ONE of the following: A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome AND ONE of the following: i. A liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight OR ii. A serum ferritin greater than 300 mcg/L OR iii. MRI confirmation of iron deposition OR B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND 2. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome OR B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication

Age Restrictions:

patient is within the fda labeled age for the requested agent for the requested indication

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

iron chelating agents pa - jadenu

Drug Name(s)

Jadenu

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. ONE of the following: A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome AND ONE of the following: i. A liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight OR ii. A serum ferritin greater than 300 mcg/L OR iii. MRI confirmation of iron deposition OR B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND 2. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome OR B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication

Age Restrictions:

patient is within the fda labeled age for the requested agent for the requested indication

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ivermectin cream pa

Drug Name(s)

Ivermectin Cream

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ivermectin tablet pa

Drug Name(s)

Ivermectin Tablet

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 4 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

jubbonti pa

Drug Name(s)

Jubbonti

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

kalydeco pa

Drug Name(s)

Kalydeco

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of cystic fibrosis AND 2. ONE of the following: A. Patient has ONE of the CFTR gene mutations or a mutation in the CFTR gene that is responsive based on in vitro data, as indicated in the FDA label, confirmed by genetic testing OR B. Patient has another CFTR gene mutation(s) that is responsive to the requested agent, as indicated in the FDA label, confirmed by genetic testing AND 3. Patient is NOT homozygous for the F508del mutation AND 4. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of cystic fibrosis AND 3. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication

Age Restrictions:

patient is within the fda labeled age for the requested agent

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., cystic fibrosis, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

kerendia pa

Drug Name(s)

Kerendia

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

leuprolide pa

Drug Name(s)

Leuprolide

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. BOTH of the following: i. Patient is NOT currently being treated with the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND 3. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

lidocaine topical pa - lidocaine patch

Drug Name(s)

Lidocaine Patch

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require BOTH of the following: 1. Patient has ONE of the following diagnoses: A. Pain associated with postherpetic neuralgia (PHN) OR B. Pain associated with diabetic neuropathy OR C. Neuropathic pain associated with cancer, or cancer treatment OR D. Another diagnosis that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. Patient has tried and had an inadequate response to a conventional therapy [e.g., gabapentin, pregabalin, oral prescription NSAID (non-steroidal anti-inflammatory drug)] for the requested indication OR B. Patient has an intolerance or hypersensitivity to a conventional therapy OR C. Patient has an FDA labeled contraindication to a conventional therapy

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

lidocaine topical pa - lidocaine/prilocaine cream

Drug Name(s)

Lidocaine/Prilocaine Cream

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. The requested agent will be used for ONE of the following: A. Local analgesia on normal intact skin OR B. Topical anesthetic for dermal procedures OR C. Adjunctive anesthesia prior to local anesthetic infiltration in adult male genital skin OR D. Anesthesia for minor procedures on female external genitalia OR E. Another indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

linezolid pa

Drug Name(s)

Linezolid

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND ONE of the following: a. The requested agent is prescribed by an infectious disease specialist or the prescriber has consulted with an infectious disease specialist on treatment of this patient OR b. Patient has a documented infection due to vancomycin-resistant Enterococcus faecium OR c. Patient has a diagnosis of pneumonia caused by Staphylococcus aureus or Streptococcus pneumoniae AND ONE of the following: i. Patient has a documented infection that is resistant to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole, OR that is resistant to vancomycin OR ii. Patient has an intolerance or hypersensitivity to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR iii. Patient has an FDA labeled contraindication to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR iv. Patient has an intolerance or hypersensitivity to vancomycin OR v. Patient has an FDA labeled contraindication to vancomycin OR d. Patient has a documented skin and skin structure infection, including diabetic foot infections, caused by Staphylococcus aureus, Streptococcus pyogenes, or Streptococcus agalactiae AND ONE of the following: i. Patient has a documented infection that is resistant to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole, OR that is resistant to vancomycin at the site of infection OR ii. Patient has an intolerance or hypersensitivity to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR iii. Patient has an FDA labeled contraindication to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR Criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 3 months

Other Criteria:

iv. Patient has an intolerance or hypersensitivity to vancomycin OR v. Patient has an FDA labeled contraindication to vancomycin AND 2. Patient will NOT be using the requested agent in combination with Sivextro (tedizolid) for the same infection AND 3. Th

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

mavyret pa

Drug Name(s)

Mavyret

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require ALL of the following: 1. ONE of the following: A. Patient has a diagnosis of hepatitis C confirmed by serological markers OR B. Patient is a hepatitis C virus (HCV) - uninfected solid organ transplant recipient AND BOTH of the following: i. Patient received an HCV - viremic donor organ AND ii. The requested agent is being used for prophylaxis AND 2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND 3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND 4. The requested dose is within FDA labeled dosing or supported in AASLD/IDSA guideline dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

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

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

memantine pa

Drug Name(s)

Memantine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

PA does NOT apply to patients greater than or equal to 30 years of age Criteria for approval require the following: 1. Patient is younger than 30 years of age AND ONE of the following: A. Patient has a diagnosis of moderate to severe dementia of the Alzheimer's type OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

methylin pa

Drug Name(s)

Methylin

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

methylphenidate er tablet pa

Drug Name(s)

Methylphenidate ER

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

miebo pa

Drug Name(s)

Miebo

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 6 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

mifepristone pa

Drug Name(s)

Mifepristone

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of Cushing's syndrome AND 2. ONE of the following: A. Patient has type 2 diabetes mellitus OR B. Patient has glucose intolerance as defined by a 2-hour glucose tolerance test plasma glucose value of 140-199 mg/dL AND 3. ONE of the following: A. Patient had an inadequate response to surgical resection OR B. Patient is NOT a candidate for surgical resection Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of Cushing's syndrome AND 3. Patient has had clinical benefit with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

migranal pa brekiya

Drug Name(s)

Migranal

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. The requested agent will be used for the treatment of acute migraine with or without aura AND 2. ONE of the following: A. Patient has tried and had an inadequate response to TWO triptan agents with differing active ingredients (e.g., sumatriptan, rizatriptan) OR B. Patient has an intolerance or hypersensitivity to ONE triptan agents with differing active ingredients OR C. Patient has an FDA labeled contraindication to ONE triptan agents with differing active ingredients AND 3. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, acute CGRP) Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. The requested agent will be used for the treatment of acute migraine with or without aura AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, acute CGRP)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

modafinil pa

Drug Name(s)

Modafinil

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another target agent (i.e., armodafinil)

Age Restrictions:

patient is 17 years of age or over

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

mounjaro pa

Drug Name(s)

Mounjaro

Indications:

Off-Label Uses:

Exclusions Criteria:

Requested agent will be used for weight loss alone

Required Medical Information:

Criteria for approval require BOTH of the following: 1. Patient has a diagnosis of type 2 diabetes mellitus AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR C. ALL of the following: i. ONE of the following: 1. Patient's medication history includes use of a non glucagon-like peptide-1 (GLP-1) oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) within the past 90 days OR 2. Patient had an ineffective treatment response to a non GLP-1 oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR 3. Patient has an intolerance or hypersensitivity to a non GLP-1 oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR 4. Patient has an FDA labeled contraindication to a non GLP-1 oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND iii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND iv. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ms pa - avonex

Drug Name(s)

Avonex

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ms pa - betaseron

Drug Name(s)

Betaseron

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ms pa - dimethyl fumarate

Drug Name(s)

Dimethyl Fumarate

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ms pa - fingolimod

Drug Name(s)

Fingolimod

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication AND 3. Prescriber has performed an electrocardiogram within 6 months prior to initiating treatment Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ms pa - glatiramer

Drug Name(s)

Glatiramer

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ms pa - kesimpta

Drug Name(s)

Kesimpta

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ms pa - plegridy

Drug Name(s)

Plegridy

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ms pa - vumerity

Drug Name(s)

Vemerity

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. Patient has an FDA labeled indication for the requested agent AND 2. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical benefit with the requested agent AND 4. Patient will NOT be using the requested agent in combination with another disease modifying agent (DMA) or a biologic immunomodulator for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

nuedexta pa

Drug Name(s)

Neudexta

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require the following: 1. ONE of the following: A. Patient has a diagnosis of pseudobulbar affect OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

nuplazid pa

Drug Name(s)

Nuplazid

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

nurtec pa

Drug Name(s)

Nurtec

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. Patient has a diagnosis of migraine AND 2. ONE of the following: A. The requested agent is being used for the treatment of acute migraine with or without aura AND BOTH of the following: i. ONE of the following: a. Patient has tried and had an inadequate response to a triptan (e.g., sumatriptan, rizatriptan) agent OR b. Patient has an intolerance, or hypersensitivity to a triptan OR c. Patient has an FDA labeled contraindication to a triptan AND ii. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP) OR B. The requested agent is being used for migraine prophylaxis AND Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of migraine AND 3. ONE of the following: A. The requested agent is being used for the treatment of acute migraine with or without aura AND BOTH of the following: i. Patient has had clinical benefit with the requested agent AND ii. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP) OR B. The requested agent is being used for migraine prophylaxis AND BOTH of the following: i. Patient has had clinical benefit with the requested agent AND ii. Patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ofev pa

Drug Name(s)

Ofev

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF) AND ii. Patient has no known explanation for interstitial lung disease (ILD) or pulmonary fibrosis (e.g., radiation, drugs, metal dusts, sarcoidosis, or any connective tissue disease known to cause ILD) OR B. BOTH of the following: i. Patient has a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) AND ii. Patient's diagnosis has been confirmed on high-resolution computed tomography (HRCT) or chest radiography scans OR C. BOTH of the following: i. Patient has a diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype AND ii. Patient's diagnosis has been confirmed on high-resolution computed tomography (HRCT) Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of ONE of the following: A. Idiopathic pulmonary fibrosis (IPF) OR B. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) OR C. Chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., pathologist, pulmonologist, radiologist, rheumatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ophthalmic immunomodulators pa - xiidra

Drug Name(s)

Xiidra

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

opioids er pa - fentanyl patch

Drug Name(s)

Fentanyl Patch

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. ONE of the following: A. Patient has a diagnosis of chronic cancer-related pain OR B. Patient has a diagnosis of pain due to sickle cell disease OR C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following: i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR iii. ALL of the following: a. Prescriber has completed a formal, consultative evaluation including BOTH of the following: 1. Diagnosis AND 2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis AND b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND d. ONE of the following: 1. Patient's medication history includes use of an immediate-acting opioid OR 2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR 3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND f. Patient does NOT have any FDA labeled contraindications to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

opioids er pa - morphine

Drug Name(s)

Morphine

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. ONE of the following: A. Patient has a diagnosis of chronic cancer-related pain OR B. Patient has a diagnosis of pain due to sickle cell disease OR C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following: i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR iii. ALL of the following: a. Prescriber has completed a formal, consultative evaluation including BOTH of the following: 1. Diagnosis AND 2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis AND b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND d. ONE of the following: 1. Patient's medication history includes use of an immediate-acting opioid OR 2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR 3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND f. Patient does NOT have any FDA labeled contraindications to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

opioids er pa - tramadol

Drug Name(s)

Tramadol

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. ONE of the following: A. Patient has a diagnosis of chronic cancer-related pain OR B. Patient has a diagnosis of pain due to sickle cell disease OR C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following: i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR iii. ALL of the following: a. Prescriber has completed a formal, consultative evaluation including BOTH of the following: 1. Diagnosis AND 2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis AND b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND d. ONE of the following: 1. Patient's medication history includes use of an immediate-acting opioid OR 2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR 3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND f. Patient does NOT have any FDA labeled contraindications to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

orkambi pa

Drug Name(s)

Orkambi

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of cystic fibrosis AND 2. ONE of the following: A. Patient has the presence of the F508del mutation on both alleles (homozygous) of the CFTR gene confirmed by genetic testing OR B. Patient has another CFTR gene mutation(s) that is responsive to the requested agent, as indicated in the FDA label, confirmed by genetic testing AND 3. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of cystic fibrosis AND 3. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication

Age Restrictions:

patient is within the fda labeled age for the requested agent

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., cystic fibrosis, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

otezla pa

Drug Name(s)

Otezla

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. ONE of the following: A. BOTH of the following: i. Patient has ONE of the following diagnoses: 1. Plaque psoriasis OR 2. Active psoriatic arthritis AND ii. ONE of the following: 1. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR 2. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR 3. Patient's medication history indicates use of a biologic immunomodulator agent for the same FDA labeled indication OR 4. Patient has tried and had an inadequate response to at least ONE conventional prerequisite agent for the requested indication OR 5. Patient has an intolerance or hypersensitivity to at least ONE conventional prerequisite agent for the requested indication OR 6. Patient has an FDA labeled contraindication to at least ONE conventional prerequisite agent for the requested indication OR B. Patient has a diagnosis of oral ulcers associated with Behcet's disease (BD) AND 2. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has ONE of the following diagnoses: A. Plaque psoriasis OR B. Active psoriatic arthritis OR C. Oral ulcers associated with Behcet's disease (BD) AND 3. Patient has had clinical benefit with the requested agent (slowing of disease progression or decrease in symptom severity, frequency, or both) AND 4. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Formulary conventional agent required for diagnoses of plaque psoriasis or active psoriatic arthritis Formulary conventional agents for plaque psoriasis include cyclosporine, methotrexate, tazarotene, topical calcitriol, or topical corticosteroids Formula

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ozempic pa

Drug Name(s)

Oxempic

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Requested agent will be used for weight loss alone

Required Medical Information:

Criteria for approval require BOTH of the following: 1. Patient has a diagnosis of type 2 diabetes mellitus AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR C. ALL of the following: i. ONE of the following: 1. Patient's medication history includes use of a non glucagon-like peptide-1 (GLP-1) oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) within the past 90 days OR 2. Patient had an ineffective treatment response to a non GLP-1 oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR 3. Patient has an intolerance or hypersensitivity to a non GLP-1 oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR 4. Patient has an FDA labeled contraindication to a non GLP-1 oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR 5. BOTH of the following: a. Patient has a diagnosis of established cardiovascular disease [e.g., myocardial infarction, stroke, any revascularization procedure, transient ischemic attack, unstable angina, amputation, symptomatic or asymptomatic coronary artery disease] AND b. The requested agent will be used to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND iii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

panretin pa

Drug Name(s)

Panretin

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require BOTH of the following: 1. ONE of the following: A. Patient has a diagnosis of cutaneous lesions associated with AIDS-related Kaposi's sarcoma (KS) OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. ALL of the following: i. ONE of the following: 1. BOTH of the following: a. Patient has a diagnosis of cutaneous lesions associated with AIDS-related Kaposi's sarcoma (KS) AND b. Patient does NOT require systemic anti-Kaposi's sarcoma therapy OR 2. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, dermatologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND iii. Patient does NOT have any FDA labeled contraindications to the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

pegylated interferon pa

Drug Name(s)

Pegylated Interferon

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require the following: 1. ONE of the following: A. Patient has a diagnosis of chronic hepatitis B AND BOTH of the following: i. The chronic hepatitis B infection has been confirmed by serological markers AND ii. Patient has NOT been administered the requested agent for more than 48 weeks for the treatment of chronic hepatitis B OR B. BOTH of the following: i. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND ii. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling for the patient's diagnosis and genotype OR C. Patient has an indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months for all other diagnoses. For hep B, hep C see Other Criteria

Other Criteria:

No prior peginterferon alfa use, approve 48 weeks for hepatitis B infection. Prior peginterferon alfa use, approve remainder of 48 weeks of total therapy for hepatitis B infection Duration of therapy for hepatitis C: Based on FDA approved labeling

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

pirfenidone pa

Drug Name(s)

Pirfenidone

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF) AND 2. Patient has no known explanation for interstitial lung disease (ILD) or pulmonary fibrosis (e.g., radiation, drugs, metal dusts, sarcoidosis, or any connective tissue disease known to cause ILD) Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of idiopathic pulmonary fibrosis (IPF)

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., pathologist, pulmonologist, radiologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

posaconazole pa

Drug Name(s)

Posaconazole

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of oropharyngeal candidiasis AND ONE of the following: i. Patient has tried and had an inadequate response to fluconazole or an alternative antifungal agent OR ii. Patient has an intolerance or hypersensitivity to fluconazole or an alternative antifungal agent OR iii. Patient has an FDA labeled contraindication to fluconazole or an alternative antifungal agent OR B. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida AND patient is severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR C. Patient has a diagnosis of invasive Aspergillus AND ONE of the following: i. Patient has tried and had an inadequate response to an alternative antifungal agent OR ii. Patient has an intolerance or hypersensitivity to an alternative antifungal agent OR iii. Patient has an FDA labeled contraindication to an alternative antifungal agent OR D. Patient has another indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

One month for oropharyngeal candidiasis, 6 months for all other indications

Other Criteria:

Criteria for renewal approval require BOTH of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. The requested agent is being prescribed for prophy

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

promacta pa

Drug Name(s)

Promacta

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. ONE of the following: A. Patient (pt) has a diagnosis of persistent or chronic immune (idiopathic) thrombocytopenia (ITP) OR B. Pt has a diagnosis of hepatitis C associated thrombocytopenia AND ONE of the following: i. the intent is to increase platelet counts sufficiently to initiate interferon therapy OR ii. Pt is on concomitant therapy with interferon therapy AND is at risk for discontinuing hepatitis C therapy due to thrombocytopenia OR C. Pt has a confirmed diagnosis of severe aplastic anemia (SAA) based on ALL of the following: i. Based on at least 2 of the following blood counts: a. Neutrophil count b. Platelet count. c Reticulocyte count AND ii. Pt has at least 1 of the following marrow criteria: 1. Severe hypocellularity OR 2. Moderate hypocellularity with hematopoietic cells representing less than 30% of residual cells AND iii. ONE of the following: 1. Pt has tried and had an insufficient response to BOTH antithymocyte globulin (ATG) AND cyclosporine therapy OR 2. BOTH of the following: a. Pt will be using the requested agent as first-line treatment (i.e., has not been treated with ATG and/or cyclosporine) AND b. Pt will use the requested agent in combination with standard immunosuppressive therapy (i.e., ATG AND cyclosporine) OR Initial criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial: 6 months for ITP. Renewal: 12 months for ITP. Other indications, see Other Criteria.

Other Criteria:

D. Pt has another indication that is supported in CMS approved compendia for the requested agent AND 2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication Criteria for renewal approva

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

pulmonary hypertension pa - adempas

Drug Name(s)

Adampas

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND ii. Patient has an FDA labeled indication for the requested agent OR B. Patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH), WHO Group 4, as determined by a ventilation-perfusion scan and a confirmatory selective pulmonary angiography AND ALL of the following: i. ONE of the following: a. Patient is NOT a candidate for surgery OR b. Patient has had pulmonary endarterectomy AND has persistent or recurrent disease ii. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ALL of the following: a. Patient's World Health Organization (WHO) functional class is II or greater AND b. Patient has a mean pulmonary arterial pressure greater than 20 mmHg AND c. Patient has a pulmonary capillary wedge pressure less than or equal to 15 mmHg AND d. Patient has a pulmonary vascular resistance greater than or equal to 3 Wood units AND Initial criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

v. ONE of the following: a. The requested agent will be utilized as monotherapy OR b. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), AND BOTH of the following: 1. Patient has unacceptable or deteriorating c

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

pulmonary hypertension pa - ambrisentan

Drug Name(s)

Ambrisentan

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND ii. Patient has an FDA labeled indication for the requested agent OR B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ONE of the following: i. The requested agent will be utilized as monotherapy OR ii. The requested agent will be used in combination with a phosphodiesterase 5 (PDE5) inhibitor for dual therapy ONLY OR iii. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), [except for dual therapy requests for a phosphodiesterase 5 (PDE 5) inhibitor plus an endothelin receptor antagonist (ERA)], AND BOTH of the following: a. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND b. The requested agent is in a different therapeutic class OR Initial criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND ALL of the following: 1. ONE of the following: i. A prostanoid has been started as one of the agents in the triple therapy OR ii. Patient has an into

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

pulmonary hypertension pa - bosentan

Drug Name(s)

Bosentan

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Elevated liver enzymes accompanied by signs or symptoms of liver dysfunction/injury or a bilirubin level of 2 times the ULN (upper limit of normal) or greater AND FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1, as determined by right heart catheterization, AND ONE of the following: i. The requested agent will be utilized as monotherapy OR ii. The requested agent will be used in combination with a phosphodiesterase 5 (PDE5) inhibitor for dual therapy ONLY OR iii. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), [except for dual therapy requests for a phosphodiesterase 5 inhibitor (PDE5) plus an endothelin receptor antagonist (ERA)], AND BOTH of the following: a. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND b. The requested agent is in a different therapeutic class OR Initial criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND ALL of the following: 1. ONE of the following: i. A prostanoid has been started as one of the agents in the triple therapy OR ii. Patient has an into

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

pulmonary hypertension pa - opsumit

Drug Name(s)

Opsumit

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND ii. Patient has an FDA labeled indication for the requested agent OR B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ONE of the following: i. The requested agent will be utilized as monotherapy OR ii. The requested agent will be used in combination with a phosphodiesterase 5 (PDE5) inhibitor for dual therapy ONLY OR iii. The requested agent will be utilized for add-on therapy to existing monotherapy (dual therapy), [except for dual therapy requests for a phosphodiesterase 5 (PDE 5) inhibitor plus an endothelin receptor antagonist (ERA)], AND BOTH of the following: a. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND b. The requested agent is in a different therapeutic class OR Initial criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy), AND ALL of the following: 1. ONE of the following: i. A prostanoid has been started as one of the agents in the triple therapy OR ii. Patient has an into

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

pulmonary hypertension pa - sildenafil

Drug Name(s)

Sildenafil

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Concurrently taking another phosphodiesterase 5 (PDE 5) inhibitor with the requested agent AND FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ONE of the following: i. The requested agent will be utilized as monotherapy OR ii. The requested agent will be used in combination with an endothelin receptor antagonist (ERA) for dual therapy ONLY OR iii. The requested agent will be utilized for add-on therapy to existing monotherapy, [except for dual requests for a phosphodiesterase 5 (PDE5) inhibitor plus an endothelin receptor antagonist (ERA)], AND BOTH of the following: a. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND b. The requested agent is in a different therapeutic class OR Initial criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy) AND ALL of the following: 1. ONE of the following: i. A prostanoid has been started as one of the agents in the triple therapy OR ii. Patient has an intol

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

pulmonary hypertension pa - tadalafil

Drug Name(s)

Tadalafil

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Concurrently taking another phosphodiesterase 5 (PDE 5) inhibitor with the requested agent AND FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require the following: 1. ONE of the following: A. BOTH of the following: i. ONE of the following: a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR b. Prescriber states the patient is currently being treated with the requested agent within the past 90 days AND ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR B. Patient has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 as determined by right heart catheterization AND ONE of the following: i. The requested agent will be utilized as monotherapy OR ii. The requested agent will be used in combination with an endothelin receptor antagonist (ERA) for dual therapy ONLY OR iii. The requested agent will be utilized for add-on therapy to existing monotherapy, [except for dual requests for a phosphodiesterase 5 (PDE5) inhibitor plus an endothelin receptor antagonist (ERA)], AND BOTH of the following: a. Patient has unacceptable or deteriorating clinical status despite established PAH pharmacotherapy AND b. The requested agent is in a different therapeutic class OR Initial criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

d. The requested agent will be utilized for add-on therapy to existing dual therapy (triple therapy) AND ALL of the following: 1. ONE of the following: i. A prostanoid has been started as one of the agents in the triple therapy OR ii. Patient has an intol

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

pyrimethamine pa

Drug Name(s)

Pyrimethamine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 6 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

pyrukynd pa

Drug Name(s)

Pyrukynd

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

quinine pa

Drug Name(s)

Quinine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require the following: 1. Patient has ONE of the following diagnoses: A. Uncomplicated malaria OR B. Babesiosis OR C. An indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

7 days for malaria, 10 days for babesiosis, 12 months for all other diagnoses

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

repatha pa

Drug Name(s)

Repatha

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has ONE of the following: A. A diagnosis of heterozygous familial hypercholesterolemia (HeFH) OR B. A diagnosis of homozygous familial hypercholesterolemia (HoFH) OR C. A diagnosis of established cardiovascular disease [acute coronary syndrome (ACS), history of myocardial infarction (MI), stable or unstable angina, coronary or other arterial revascularization stroke, transient ischemic attack (TIA), peripheral artery disease (PAD) including aortic aneurysm] AND the requested agent will be used to reduce the risk of myocardial infarction, stroke OR D. A diagnosis of primary hyperlipidemia (not associated with HeFH, HoFH, or established cardiovascular disease) OR E. Patient has another indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. Patient has tried and had an inadequate response to a high-intensity statin (i.e., rosuvastatin 20-40 mg or atorvastatin 40-80 mg) OR B. Patient has an intolerance to TWO different statins OR C. Patient has an FDA labeled contraindication to a statin AND 3. Patient will NOT be using the requested agent in combination with another PCSK9 agent see Other Criteria

Age Restrictions:

Prescriber Restrictions:

The agent was prescribed by, or in consultation with, a cardiologist, an endocrinologist, a PCP for MACE indication, or a physician who focuses in the treatment of cardiovascular (CV) risk management, lipid disorders, or both.

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication or an indication that is supported in

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

rezurock pa

Drug Name(s)

Rezurock

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ritalin pa

Drug Name(s)

Ritalin

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require the following: 1. Patient has an FDA labeled indication for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

sapropterin pa

Drug Name(s)

Sapropterin

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of phenylketonuria (PKU) AND 2. Prescriber has submitted a baseline blood Phe level measured prior to initiation of therapy with the requested agent, which is above the recommended levels indicated for the patient's age range or condition AND 3. Patient will NOT be using the requested agent in combination with Palynziq (pegvaliase-pqpz) for the requested indication AND 4. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of phenylketonuria (PKU) AND 3. ONE of the following: a. Patient's blood Phe levels are being maintained within the acceptable range OR b. Patient has had a decrease in blood Phe level from baseline AND 4. Patient will NOT be using the requested agent in combination with Palynziq (pegvaliase-pqpz) for the requested indication AND 5. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., metabolic or genetic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Initial: 2 months if dose is 5 to less than 20 mg/kg/day, 1 month if 20 mg/kg/day
Renewal: 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

self - administered oncology pa - abirtega

Drug Name(s)

abirtega

akeega

alecensa

alunbrig

augtyro

avma-fakz

ayvakit

balversa

besremi

bexarotene

bosulif

braftovi

brukinsa

cabometyx

caprelsa

cinryze

cometriq

copiktra

cotellic

danziten

daurismo

erivedge

erleada

erlontinib

fruzaqla

gavreto

gefitinib

gilotrif

gomek

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require BOTH of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. ALL of the following: i. Genetic testing, if required by FDA or compendia, has been completed, for therapy with the requested agent and results indicate the requested agent is appropriate AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND iii. ONE of the following: a. The requested agent is FDA labeled or supported by CMS approved compendia as a first-line therapy for the requested indication OR b. Patient has tried appropriate FDA labeled or CMS approved compendia supported therapy that are indicated as first-line therapy for the requested indication OR c. Patient has an intolerance or hypersensitivity to the first-line therapy for

the requested indication OR d. Patient has an FDA labeled contraindication to the first-line therapy for the requested indication AND iv. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines AND Criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

signifor pa

Drug Name(s)

Signifor

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Severe hepatic impairment (i.e., Child Pugh C)

Required Medical Information:

Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of Cushing's disease (CD) AND ONE of the following: i. Patient had an inadequate response to pituitary surgical resection OR ii. Patient is NOT a candidate for pituitary surgical resection OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent Criteria for renewal approval require BOTH of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of Cushing's disease (CD) AND BOTH of the following: i. Patient has a urinary free cortisol level less than or equal to the upper limit of normal AND ii. Patient has had improvement in at least ONE of the following clinical signs and symptoms: 1. Fasting plasma glucose OR 2. Hemoglobin A1c OR 3. Hypertension OR 4. Weight OR B. BOTH of the following: i. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Patient has had clinical benefit with the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial approval: 6 months for CD, 12 months for all other diagnoses, Renewal approval: 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

sivextro pa

Drug Name(s)

Sivextro

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require ALL of the following: 1. Patient has ONE of the following: A. BOTH of the following: i. A documented acute bacterial skin and skin structure infection (ABSSSI) defined as a bacterial infection of the skin with a lesion size area of at least 75 cm2 (lesion size measured by the area of redness, edema, or induration) AND ii. The infection is due to Staphylococcus aureus, Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus anginosus, Streptococcus intermedius, Streptococcus constellatus, or Enterococcus faecalis OR B. Another indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. The requested agent is prescribed by an infectious disease specialist or the prescriber has consulted with an infectious disease specialist on treatment of this patient OR B. The requested agent is NOT prescribed by an infectious disease specialist or the prescriber has NOT consulted with an infectious disease specialist on treatment of this patient AND ONE of the following: i. There is documentation of resistance to TWO of the following: beta-lactams, macrolides, clindamycin, tetracycline, or co-trimoxazole at the site of infection OR ii. Patient has an intolerance or hypersensitivity to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR iii. Patient has an FDA labeled contraindication to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR iv. There is documentation of resistance to vancomycin at the site of infection OR v. Patient has an intolerance or hypersensitivity to vancomycin OR vi. Patient has an FDA labeled contraindication to vancomycin AND 3. Patient will NOT be using the requested agent in combination with linezolid for the same infection AND 4. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Age Restrictions:

patient is within the fda labeled age for the requested agent

Prescriber Restrictions:

Coverage Duration:

Approval will be 6 days for ABSSSI or 30 days for all other indications

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

sodium oxybate pa

Drug Name(s)

Sodium Oxybate

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require the following: 1. ONE of the following: A. Patient has a diagnosis of narcolepsy with cataplexy OR B. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness AND BOTH of the following: i. ONE of the following: a. Patient is under 18 years of age OR b. ONE of the following: 1. Patient has tried and had an inadequate response to modafinil or armodafinil OR 2. Patient has an intolerance or hypersensitivity to modafinil or armodafinil OR 3. Patient has an FDA labeled contraindication to modafinil or armodafinil AND C. Patient has another indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

patient is 7 years of age or over

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

somatostatin analogs pa - octreotide

Drug Name(s)

Octreotide

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. ONE of the following: A. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND ONE of the following: i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR ii. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR B. ONE of the following: i. Patient has a diagnosis of acromegaly AND ONE of the following: a. Patient is not a candidate for surgical resection or pituitary radiation therapy OR b. The requested agent is for adjunctive therapy with pituitary radiation therapy OR c. Patient had an inadequate response to surgery or pituitary radiation therapy as indicated by growth hormone levels or serum IGF-1 levels that are above the reference range OR ii. Patient has severe diarrhea, flushing episodes, or both associated with metastatic carcinoid tumors OR iii. Patient has profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors OR iv. Patient has a diagnosis of dumping syndrome OR v. Patient has another indication that is supported in CMS approved compendia for the requested agent AND 2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be 6 months for initial, 12 months for renewal

Other Criteria:

Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has a diagnosis of acromegaly OR B. Patient

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

somatostatin analogs pa - somavert

Drug Name(s)

Somavert

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require BOTH of the following 1. Patient has a diagnosis of acromegaly AND ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR C. ONE of the following: i. Patient is not a candidate for surgical resection or pituitary radiation therapy OR ii. The requested agent is for adjunctive therapy with pituitary radiation therapy OR iii. Patient had an inadequate response to surgery or pituitary radiation therapy as indicated by serum IGF-1 levels that are above the reference range AND 2. The requested dose is within FDA labeled dosing for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of acromegaly AND 3. Patient has had clinical benefit with the requested agent AND 4. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be 6 months for initial, 12 months for renewal

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

substrate reduction therapy pa - miglustat

Drug Name(s)

Miglustat

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a confirmed diagnosis of Gaucher disease type 1 (GD1) AND 2. Prescriber has drawn baseline (prior to therapy for the requested indication) measurements of hemoglobin level, platelet count, liver volume, and spleen volume AND 3. Prior to any treatment for the intended diagnosis, the patient has had at least ONE of the following clinical presentations: A. Anemia [defined as mean hemoglobin (Hb) level below the testing laboratory's lower limit of the normal range based on age and gender] OR B. Thrombocytopenia (defined as platelet count of less than 100,000 per microliter) OR C. Hepatomegaly OR D. Splenomegaly OR E. Growth failure (i.e., growth velocity is below the standard mean for age) OR F. Evidence of bone disease with other causes ruled out Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of Gaucher disease type 1 (GD1)

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, geneticist, hematologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

tasimelteon capsule pa

Drug Name(s)

Tasimelteon Capsule

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require the following: 1. ONE of the following: A. BOTH of the following: i. Patient has a diagnosis of Non-24-hour sleep-wake disorder AND ii. Patient is totally blind (i.e., no light perception) OR B. BOTH of the following: i. Patient has a diagnosis of Smith-Magenis Syndrome (SMS) confirmed by the presence of ONE of the following genetic mutations: A. A heterozygous deletion of 17p11.2 OR B. A heterozygous pathogenic variant involving RAI1 AND ii. The requested agent is being used to treat nighttime sleep disturbances associated with SMS

Age Restrictions:

for diagnosis of non-24-hour sleep-wake disorder, patient is 18 years of age or over. for diagnosis of smith-magenis syndrome (sms), patient is 16 years of age or over.

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist, sleep specialist, psychiatrist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

teriparatide pa

Drug Name(s)

Teriparatide

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require ALL of the following: 1. Patient has ONE of the following: A. Postmenopausal osteoporosis OR B. Patient's sex is male with primary or hypogonadal osteoporosis OR C. Osteoporosis with sustained systemic glucocorticoid therapy AND 2. Patient's diagnosis has been confirmed using conventional methods 3. Patient is at a very high fracture risk as defined by ONE of the following: a. Patient had a recent fracture (within the past 12 months) OR b. Patient had fractures while on FDA approved osteoporosis therapy OR c. Patient has had multiple fractures OR d. Patient had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR e. Patient has a very low T-score (less than -3.0) OR f. Patient is at high risk for falls or has a history of injurious falls OR g. Patient has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm 4. Patient will NOT be using the requested agent in combination with a bisphosphonate, denosumab (e.g., Prolia, Xgeva), romosozumab-aqqg, or another parathyroid hormone analog (e.g., abaloparatide) for the requested indication AND Criteria continues: see Other Criteria

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

No prior teriparatide, Tymlos, or both use approve 2 years, unless high risk of fracture remainsPrior use - see Other Criteria

Other Criteria:

5. The requested dose is within FDA labeled dosing for the requested indication AND 6. ONE of the following: A. Patient has never received treatment with teriparatide or Tymlos (abaloparatide) OR B. Patient has been previously treated with teriparatide or

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

tetrabenazine pa

Drug Name(s)

Tetrabenazine

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require ALL of the following: 1. ONE of the following: A. Patient has a diagnosis of chorea associated with Huntington's disease OR B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. Patient does NOT have a current diagnosis of depression OR B. Patient has a current diagnosis of depression and is being treated for depression AND 3. ONE of the following: A. Patient does NOT have a diagnosis of either suicidal ideation or behavior OR B. Patient has a diagnosis of suicidal ideation or suicidal behavior and must NOT be actively suicidal AND 4. Patient will NOT be using the requested agent in combination with a monoamine oxidase inhibitor (MAOI) AND 5. Patient will NOT be using the requested agent in combination with reserpine

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

tobramycin neb pa

Drug Name(s)

Tobramycin

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require ALL of the following: 1. Patient has a diagnosis of cystic fibrosis AND 2. Documentation has been provided that indicates the patient has a Pseudomonas aeruginosa respiratory infection AND 3. ONE of the following: a. Patient is NOT currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam, inhaled tobramycin) OR b. Patient is currently (within the past 60 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam, inhaled tobramycin) AND ONE of the following: i. Prescriber has confirmed that the other inhaled antibiotic will be discontinued, and that therapy will be continued only with the requested agent OR ii. Prescriber has provided information in support of another inhaled antibiotic therapy used concurrently with or alternating with (i.e., continuous alternating therapy) the requested agent Drug is also subject to Part B versus Part D review.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

topical diclofenac 3% gel pa

Drug Name(s)

Topical Diclofenac 3% Gel

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require the following: 1. Patient has a diagnosis of actinic keratosis (AK)

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 3 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

topical nsaid pa - pennsaid

Drug Name(s)

Pennsaid

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

topical retinoids pa - tazarotene

Drug Name(s)

Tazarotene

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Requested agent will be used for cosmetic purposes

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

topical retinoids pa - tretinoin

Drug Name(s)

Tretinoin

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Requested agent will be used for cosmetic purposes

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

trelstar pa

Drug Name(s)

Trelstar

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. BOTH of the following: i. Patient is NOT currently being treated with the requested agent AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND 3. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

trientine pa

Drug Name(s)

Trientine

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. Patient has a confirmed diagnosis of Wilson's disease AND 2. ONE of the following: A. Patient has tried and had an inadequate response to penicillamine OR B. Patient has an intolerance or hypersensitivity to penicillamine OR C. Patient has an FDA labeled contraindication to penicillamine Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of Wilson's disease AND 3. Patient has had clinical benefit with the requested agent as evidenced by ONE of the following: A. Improvement, stabilization, or both in hepatic abnormality OR B. Reduction in Kayser-Fleischer rings OR C. Improvement, stabilization, or both in neurological symptoms (e.g., dystonia, hypertonia, rigidity with tremors, dysarthria, muscle spasms, dysphasia, polyneuropathy, dysautonomia) OR D. Basal urinary copper excretion greater than 200 mcg/24 hours

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist, neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

trikafta pa

Drug Name(s)

Trikafta

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of cystic fibrosis AND 2. ONE of the following: A. Patient has the presence of the F508del mutation in at least ONE allele (heterozygous OR homozygous) of the CFTR gene confirmed by genetic testing OR B. Patient has ONE of the CFTR gene mutations or a mutation in the CFTR gene that is responsive based on in vitro data, as indicated in the FDA label, confirmed by genetic testing OR C. Patient has another CFTR gene mutation(s) that is responsive to the requested agent, as indicated in the FDA label, confirmed by genetic testing AND 3. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of cystic fibrosis AND 3. Patient will NOT be using the requested agent in combination with another CFTR modulator agent for the requested indication

Age Restrictions:

patient is within the fda labeled age for the requested agent

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., cystic fibrosis, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

trulicity pa

Drug Name(s)

Trulicity

Indications:

Off-Label Uses:

Exclusions Criteria:

Requested agent will be used for weight loss alone

Required Medical Information:

Criteria for approval require BOTH of the following: 1. Patient has a diagnosis of type 2 diabetes mellitus AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR C. ALL of the following: i. ONE of the following: 1. Patient's medication history includes use of a non glucagon-like peptide-1 (GLP-1) oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) within the past 90 days OR 2. Patient had an ineffective treatment response to a non GLP-1 oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR 3. Patient has an intolerance or hypersensitivity to a non GLP-1 oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR 4. Patient has an FDA labeled contraindication to a non GLP-1 oral diabetes medication (e.g., metformin, an agent containing metformin, glipizide) OR 5. BOTH of the following: a. Patient has a diagnosis of established cardiovascular disease [e.g., myocardial infarction, stroke, any revascularization procedure, transient ischemic attack, unstable angina, amputation, symptomatic or asymptomatic coronary artery disease] AND b. The requested agent will be used to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) AND ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND iii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND iv. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

tymlos pa

Drug Name(s)

Tymlos

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for approval require ALL of the following: 1. Patient (pt) has ONE of the following: A. Postmenopausal osteoporosis OR B. Pt's sex is male with osteoporosis AND 2. BOTH of the following: A. Pt's diagnosis was confirmed by ONE of the following: i. A fragility fracture in the hip or spine OR ii. A T-score of -2.5 or lower OR iii. A T-score of -1.0 to -2.5 AND ONE of the following: a. A fragility fracture of proximal humerus, pelvis, or distal forearm OR b. A FRAX 10-year probability for major osteoporotic fracture of 20% or greater OR c. A FRAX 10-year probability of hip fracture of 3% or greater AND B. ONE of the following: i. Pt is at a very high fracture risk as defined by ONE of the following: a. Pt had a recent fracture (within the past 12 months) OR b. Pt had fractures while on FDA approved osteoporosis therapy OR c. Pt has had multiple fractures OR d. Pt had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR e. Pt has a very low T-score (less than -3.0) OR f. Pt is at high risk for falls or has a history of injurious falls OR g. Pt has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm OR ii. ONE of the following: a. Pt has tried and had an inadequate response to a bisphosphonate OR b. Pt has an intolerance or hypersensitivity to a bisphosphonate OR c. Pt has an FDA labeled contraindication to a bisphosphonate AND 3. Pt will NOT be using the requested agent in combination with a bisphosphonate, denosumab (e.g., Prolia, Xgeva), romosozumab-aqqg, or another parathyroid hormone analog (e.g., teriparatide) for the requested indication AND 4. The requested dose is within FDA labeled dosing for the requested indication AND 5. The total cumulative duration of treatment with teriparatide and Tymlos (abaloparatide) has not exceeded 2 years

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

No prior Tymlos, teriparatide, or both use approve 2 years, Prior use - see Other Criteria

Other Criteria:

Prior Tymlos, teriparatide, or both use approve remainder of 2 years of total cumulative therapy

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

urea cycle disorders pa - sodium phenylbutyrate

Drug Name(s)

Sodium Phenylbutyrate

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require BOTH of the following: 1. Patient has a diagnosis of ONE of the following: a. Urea cycle disorder with neonatal-onset involving deficiencies of carbamylphosphate synthetase, ornithine transcarbamylase, or argininosuccinic acid synthetase OR b. Urea cycle disorder with late-onset and history of hyperammonemic encephalopathy involving deficiencies of carbamylphosphate synthetase, ornithine transcarbamylase, or argininosuccinic acid synthetase AND 2. The requested dose is within FDA labeled dosing for the requested indication

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist, metabolic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

valchlor pa

Drug Name(s)

Valchlor

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. BOTH of the following: i. ONE of the following: a. BOTH of the following: 1. Patient has a diagnosis of Stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma AND 2. Patient's medication history indicates use of at least ONE prior skin-directed therapy (e.g., topical corticosteroid) OR b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist, oncologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

veozah-pa

Drug Name(s)

Veozah

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

voriconazole pa

Drug Name(s)

Voriconazole

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for initial approval require the following: 1. ONE of the following: A. Patient has a diagnosis of invasive Aspergillus OR B. Patient has a serious infection caused by Scedosporium apiospermum or Fusarium species OR C. Patient has a diagnosis of esophageal candidiasis or candidemia in nonneutropenic patient AND ONE of the following: i. Patient has tried and had an inadequate response to fluconazole or an alternative antifungal agent OR ii. Patient has an intolerance or hypersensitivity to fluconazole or an alternative antifungal agent OR iii. Patient has an FDA labeled contraindication to fluconazole or an alternative antifungal agent OR D. Patient has a diagnosis of blastomycosis AND ONE of the following: i. Patient has tried and had an inadequate response to itraconazole OR ii. Patient has an intolerance or hypersensitivity to itraconazole OR iii. Patient has an FDA labeled contraindication to itraconazole OR E. The requested agent is being prescribed for prophylaxis of invasive Aspergillus or Candida AND patient is severely immunocompromised, such as a hematopoietic stem cell transplant [HSCT] recipient, or hematologic malignancy with prolonged neutropenia from chemotherapy, or is a high-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient, or long term use of high dose corticosteroids (greater than 1 mg/kg/day of prednisone or equivalent) OR F. Patient has another indication that is supported in CMS approved compendia for the requested agent

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Three months for esophageal candidiasis, 6 months for all other indications

Other Criteria:

Criteria for renewal approval require BOTH of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. ONE of the following: A. Patient has continued indicators of active diseas

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

vyndamax pa

Drug Name(s)

Vyndamax

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) AND 2. The diagnosis has been confirmed by testing [e.g., stannous pyrophosphate (PYP) scanning, monoclonal antibody studies, biopsy, scintigraphy, genetic testing] AND 3. The requested agent will be used to reduce cardiovascular mortality and cardiovascular-related hospitalization AND 4. Patient will NOT be using the requested agent in combination with another tafamidis agent for the requested indication Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) AND 3. The requested agent will be used to reduce cardiovascular mortality and cardiovascular-related hospitalization AND 4. Patient has had clinical benefit with the requested agent AND 5. Patient will NOT be using the requested agent in combination with another tafamidis agent for the requested indication

Age Restrictions:

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

wyost pa

Drug Name(s)

Wyost

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

xdemvy pa

Drug Name(s)

Xdemvy

Indications:

All medically accepted indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 2 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

xermelo pa

Drug Name(s)

Xermelo

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. Patient has a diagnosis of carcinoid syndrome diarrhea AND 2. Patient has tried and had an inadequate response to treatment with a somatostatin analog (e.g., Sandostatin [octreotide], Sandostatin LAR [octreotide], Somatuline Depot [lanreotide]) AND 3. The requested agent will be used in combination with a somatostatin analog (e.g., Sandostatin [octreotide], Sandostatin LAR [octreotide], Somatuline Depot [lanreotide]) Criteria for renewal approval require ALL of the following: 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has a diagnosis of carcinoid syndrome diarrhea AND 3. Patient has had clinical benefit with the requested agent (e.g., reduction in the average number of daily bowel movements) AND 4. The requested agent will be used in combination with a somatostatin analog (e.g., Sandostatin [octreotide], Sandostatin LAR [octreotide], Somatuline Depot [lanreotide])

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

xifaxan pa

Drug Name(s)

Xifaxan

Indications:

Off-Label Uses:

Exclusions Criteria:

FDA labeled contraindications to the requested agent

Required Medical Information:

Criteria for approval require the following: 1. Patient has ONE of the following: a. A diagnosis of irritable bowel syndrome with diarrhea (IBS-D) OR b. A diagnosis of hepatic encephalopathy [reduction in risk of overt hepatic encephalopathy (HE) recurrence] OR c. BOTH of the following: i. A diagnosis of traveler's diarrhea (TD) AND ii. The traveler's diarrhea is caused by noninvasive strains of Escherichia coli

Age Restrictions:

for diagnosis of traveler's diarrhea (td), patient is within the fda labeled age for the requested agent

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

xolair pa

Drug Name(s)

Xolair

Indications:

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require ALL of the following: 1. ONE of the following: A. Patient has a diagnosis of moderate to severe persistent asthma AND ALL of the following: i. ONE of the following: a. Patient is 6 to less than 12 years of age AND BOTH of the following: I. Patient's pretreatment IgE level is 30 IU/mL to 1300 IU/mL AND II. Patient's weight is 20 kg to 150 kg OR b. Patient is 12 years of age or over AND BOTH of the following: I. Patient's pretreatment IgE level is 30 IU/mL to 700 IU/mL AND II. Patient's weight is 30 kg to 150 kg AND ii. Allergic asthma has been confirmed by a positive skin test or in vitro reactivity test to a perennial aeroallergen AND iii. ONE of the following: a. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LRTA, LAMA, theophylline) in combination with the requested agent OR b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an asthma control therapy OR B. Patient has a diagnosis of chronic idiopathic urticaria AND BOTH of the following: i. Patient has had over 6 weeks of hives and itching AND ii. ONE of the following: a. Patient has tried and had an inadequate response to maximum tolerable H1 antihistamine therapy OR b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to H1 antihistamine therapy OR C. Patient has a diagnosis of nasal polyps AND BOTH of the following: i. ONE of the following: a. Patient has tried and had an inadequate response to an intranasal corticosteroid OR b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an intranasal corticosteroid AND ii. ONE of the following: a. The requested agent will be used in combination with an intranasal corticosteroid OR b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an intranasal corticosteroid OR Initial criteria continues: see Other Criteria

Age Restrictions:

for diagnosis of moderate to severe persistent asthma, patient is 6 years of age or over. for diagnosis of chronic idiopathic urticaria, patient is 12 years of age or over. for diagnosis of nasal polyps, patient is 18 years of age or over. for diagnosis o

Prescriber Restrictions:

Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, otolaryngologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Coverage Duration:

Approval will be 6 months for initial, 12 months for renewal

Other Criteria:

D. Patient has a diagnosis of IgE-mediated food allergy AND ALL of the following: i. Patient is using the requested agent for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods

Part B Prerequisite:

Prerequisite Therapy Required:

Prior Authorization Group Description

ztalmy pa

Drug Name(s)

Ztalmy

Indications:

All FDA-approved indications

Off-Label Uses:

Exclusions Criteria:

Required Medical Information:

Criteria for initial approval require BOTH of the following: 1. Patient has a diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) AND 2. ONE of the following: A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR B. Prescriber states the patient is currently being treated with the requested agent OR C. BOTH of the following: i. Patient's diagnosis has been confirmed with genetic testing indicating variant in CDKL5 gene AND ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis

Age Restrictions:

patient is within the fda labeled age for the requested agent

Prescriber Restrictions:

Coverage Duration:

Approval will be for 12 months

Other Criteria:

Part B Prerequisite:

Prerequisite Therapy Required: