# PA Criteria

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| ***Prior Authorization Group*** | ABIRATERONE |
| ***Drug Names*** | ABIRATERONE ACETATE, ABIRTEGA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Node-positive (N1), non-metastatic (M0) prostate cancer, very-high-risk prostate cancer, non-metastatic high-risk prostate cancer, non-metastatic prostate cancer with prostate-specific antigen (PSA) persistence/recurrence after radical prostatectomy, salivary gland tumors |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For all indications: the requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. For salivary gland tumors: the requested drug is being used for the treatment of recurrent androgen receptor positive disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ABRYSVO |
| ***Drug Names*** | ABRYSVO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the prevention of lower respiratory tract disease (LRTD) and severe LRTD caused by respiratory syncytial virus (RSV): The patient has not previously received an RSV vaccine (i.e., Abrysvo, Arexvy, Mresvia). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ACITRETIN |
| ***Drug Names*** | ACITRETIN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For psoriasis: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate or cyclosporine. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | ACTIMMUNE |
| ***Drug Names*** | ACTIMMUNE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Mycosis fungoides, Sezary syndrome |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ADEMPAS |
| ***Drug Names*** | ADEMPAS |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 2 Wood units. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): 1) Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR 2) Patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | AIMOVIG |
| ***Drug Names*** | AIMOVIG |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial: 3 months, Continuation: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | AKEEGA |
| ***Drug Names*** | AKEEGA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ALBENDAZOLE |
| ***Drug Names*** | ALBENDAZOLE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Ascariasis, trichuriasis, microsporidiosis |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Hydatid disease, Microsporidiosis: 6 months, All other indications: 1 month |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ALDURAZYME |
| ***Drug Names*** | ALDURAZYME |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For mucopolysaccharidosis I (MPS I): Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity and/or by genetic testing. Patients with Scheie form (i.e., attenuated MPS I) must have moderate to severe symptoms. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ALECENSA |
| ***Drug Names*** | ALECENSA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC, ALK-positive anaplastic large cell lymphoma (ALCL), Erdheim-Chester Disease (ECD) with ALK-fusion, inflammatory myofibroblastic tumors (IMT) with ALK translocation (including advanced, recurrent/metastatic, or inoperable uterine sarcoma for IMT with ALK translocation), ALK-positive large B-cell lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): 1) the patient meets either of the following: a) the disease is recurrent, advanced, or metastatic OR b) the requested drug will be used as adjuvant treatment following tumor resection, AND 2) the disease is anaplastic lymphoma kinase (ALK)-positive. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ALOSETRON |
| ***Drug Names*** | ALOSETRON HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For severe diarrhea-predominant irritable bowel syndrome (IBS): 1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female, 2) chronic IBS symptoms lasting at least 6 months, 3) gastrointestinal tract abnormalities have been ruled out, AND 4) inadequate treatment response to one conventional therapy (e.g., antispasmodics, antidepressants, antidiarrheals). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | ALPHA1-PROTEINASE INHIBITOR |
| ***Drug Names*** | ARALAST NP, PROLASTIN-C, ZEMAIRA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema, AND 2) pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 milligrams per deciliter [mg/dL] by radial immunodiffusion or 50 mg/dL by nephelometry). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ALUNBRIG |
| ***Drug Names*** | ALUNBRIG |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC, ALK-positive anaplastic large cell lymphoma (ALCL), inflammatory myofibroblastic tumors (IMT) with ALK translocation (including advanced, recurrent/metastatic, or inoperable uterine sarcoma for IMT with ALK translocation), Erdheim-Chester disease (ECD) with ALK-fusion |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the disease is anaplastic lymphoma kinase (ALK)-positive. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ALVAIZ |
| ***Drug Names*** | ALVAIZ |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic or persistent immune thrombocytopenia (ITP) (new starts): 1) Patient (pt) has experienced an inadequate treatment response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, AND 2) Untransfused platelet (plt) count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease, anticoagulation therapy, profession or lifestyle that predisposes pt to trauma). For ITP (continuation): plt count response to the requested drug: 1) Current plt count is less than or equal to 200,000/mcL, OR 2) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C (new starts): the requested drug is used for initiation and maintenance of interferon-based therapy. For thrombocytopenia associated with chronic hepatitis C (continuation): pt is receiving interferon-based therapy. For severe aplastic anemia (AA) (new starts): Pt had an insufficient response to immunosuppressive therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks |
| ***Other Criteria*** | For severe AA (continuation): 1) Current plt count is 50,000-200,000/mcL, OR 2) Current plt count is less than 50,000/mcL and pt has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and pt is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count. APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL). |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | ALYFTREK |
| ***Drug Names*** | ALYFTREK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystic fibrosis: the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor). |
| ***Age Restrictions*** | 6 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | AMBRISENTAN |
| ***Drug Names*** | AMBRISENTAN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 2 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | AMPHETAMINES |
| ***Drug Names*** | AMPHETAMINE/DEXTROAMPHETA |
| ***PA Indication Indicator*** | All Medically-accepted Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR 2) The patient has a diagnosis of narcolepsy confirmed by a sleep study. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ARCALYST |
| ***Drug Names*** | ARCALYST |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Prevention of gout flares in patients initiating or continuing urate-lowering therapy |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance, or contraindication to maximum tolerated doses of a non-steroidal anti-inflammatory drug (NSAID) and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (continuation): 1) patient must have achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug. For recurrent pericarditis: patient must have had an inadequate response, intolerance, or contraindication to maximum tolerated doses of a NSAID and colchicine. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | AREXVY |
| ***Drug Names*** | AREXVY |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the prevention of lower respiratory tract disease (LRTD) and severe LRTD caused by respiratory syncytial virus (RSV): The patient has not previously received an RSV vaccine (i.e., Abrysvo, Arexvy, Mresvia). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ARIKAYCE |
| ***Drug Names*** | ARIKAYCE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ARMODAFINIL |
| ***Drug Names*** | ARMODAFINIL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For excessive sleepiness associated with narcolepsy: The diagnosis has been confirmed by sleep lab evaluation. For excessive sleepiness associated with obstructive sleep apnea (OSA): The diagnosis has been confirmed by polysomnography or home sleep apnea testing (HSAT) with a technically adequate device. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | AUGTYRO |
| ***Drug Names*** | AUGTYRO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent ROS1-positive non-small cell lung cancer (NSCLC), recurrent neurotrophic tyrosine receptor kinase (NTRK) gene fusion positive NSCLC, NTRK gene fusion positive solid tumors that are not locally advanced or metastatic |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For ROS1-positive non-small cell lung cancer (NSCLC): the patient has recurrent, advanced, or metastatic disease. For neurotrophic tyrosine receptor kinase (NTRK) gene fusion positive NSCLC: the patient has recurrent, advanced, or metastatic disease. For solid tumors: the tumor is NTRK gene fusion positive. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | AUSTEDO |
| ***Drug Names*** | AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRAT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For tardive dyskinesia, initial: patient must meet both of the following: 1) patient exhibits clinical manifestations of the disease, AND 2) patient's disease has been assessed through clinical examination or with a structured evaluative tool (e.g., Abnormal Involuntary Movement Scale [AIMS], Dyskinesia Identification System: Condensed User Scale [DISCUS]). For chorea associated with Huntington's disease, initial: patient demonstrates characteristic motor examination features. For tardive dyskinesia and chorea associated with Huntington's disease, continuation: patient demonstrates a beneficial response to therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial: 6 months, continuation: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | AUVELITY |
| ***Drug Names*** | AUVELITY |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For Major Depressive Disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | AVMAPKI-FAKZYNJA |
| ***Drug Names*** | AVMAPKI FAKZYNJA CO-PACK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | AYVAKIT |
| ***Drug Names*** | AYVAKIT |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Myeloid and lymphoid neoplasms with eosinophilia, gastrointestinal stromal tumor (GIST) for residual, unresectable, tumor rupture, or recurrent/metastatic disease without platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For myeloid and lymphoid neoplasms with eosinophilia, the patient meets all of the following criteria: 1) The disease is FIP1L1- PDGFRA rearrangement-positive, AND 2) The disease harbors a PDGFRA D842V mutation, AND 3) The disease is resistant to imatinib. For GIST, the patient meets either of the following criteria: 1) The disease harbors PDGFRA exon 18 mutation, including a PDGFRA D842V mutation, OR 2) The requested drug will be used after failure on at least two Food and Drug Administration (FDA)-approved therapies in residual, unresectable, tumor rupture, or recurrent/metastatic disease without PDGFRA exon 18 mutation. For systemic mastocytosis: 1) The patient has a diagnosis of indolent systemic mastocytosis or advanced systemic mastocytosis (including aggressive systemic mastocytosis [ASM], systemic mastocytosis with associated hematological neoplasm [SM-AHN], and mast cell leukemia [MCL]) AND 2) The patient has a platelet count of greater than or equal to 50,000/microliter (mcL). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | B VS. D |
| ***Drug Names*** | ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADMELOG, ALBUTEROL SULFATE, AMINOSYN II, AMINOSYN-PF, AMPHOTERICIN B, AMPHOTERICIN B LIPOSOME, APREPITANT, ARFORMOTEROL TARTRATE, ASTAGRAF XL, AZACITIDINE, AZATHIOPRINE, BENDAMUSTINE HYDROCHLORID, BENDEKA, BUDESONIDE, CALCITONIN-SALMON, CALCITRIOL, CARBOPLATIN, CINACALCET HYDROCHLORIDE, CISPLATIN, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX 6/5, CLINIMIX 8/10, CLINIMIX 8/14, CLINISOL SF 15%, CLINOLIPID, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOPHOSPHAMIDE MONOHYDR, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DEXTROSE 50%, DEXTROSE 70%, DOCETAXEL, DOCIVYX, DOXERCALCIFEROL, DOXORUBICIN HCL, DOXORUBICIN HYDROCHLORIDE, DRONABINOL, ENGERIX-B, ETOPOSIDE, EVEROLIMUS, FIASP, FIASP PUMPCART, FLUOROURACIL, FORMOTEROL FUMARATE, FRINDOVYX, FULVESTRANT, GAMASTAN, GANCICLOVIR, GEMCITABINE HCL, GEMCITABINE HYDROCHLORIDE, GENGRAF, GRANISETRON HYDROCHLORIDE, HEPARIN SODIUM, HEPLISAV-B, HUMULIN R U-500 (CONCENTR, IBANDRONATE SODIUM, IMOVAX RABIES (H.D.C.V.), INTRALIPID, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, IRINOTECAN HYDROCHLORIDE, JYLAMVO, JYNNEOS, KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HCL, LEVALBUTEROL HYDROCHLORID, LEVOCARNITINE, LIDOCAINE HCL, LIDOCAINE HYDROCHLORIDE, LIDOCAINE/PRILOCAINE, METHOTREXATE, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MORPHINE SULFATE, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NOVOLIN R, NOVOLOG, NOVOLOG RELION, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON HYDROCHLORIDE, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PACLITAXEL PROTEIN-BOUND, PAMIDRONATE DISODIUM, PARICALCITOL, PEMETREXED, PENTAMIDINE ISETHIONATE, PLENAMINE, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREMASOL, PROGRAF, PROSOL, RABAVERT, RECOMBIVAX HB, SIROLIMUS, TACROLIMUS, TENIVAC, TPN ELECTROLYTES, TRAVASOL, TROPHAMINE, VINCRISTINE SULFATE, VINORELBINE TARTRATE, VIVIMUSTA, XATMEP, ZOLEDRONIC ACID |
| ***PA Indication Indicator*** | All Medically-accepted Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | N/A |

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| ***Other Criteria*** | This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination. |
| ***Prerequisite Therapy Required*** | No |
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| ***Prior Authorization Group*** | BAFIERTAM |
| ***Drug Names*** | BAFIERTAM |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |
| | |
| ***Prior Authorization Group*** | BALVERSA |
| ***Drug Names*** | BALVERSA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For urothelial carcinoma: 1) disease has susceptible fibroblast growth factor receptor 3 (FGFR3) genetic alterations, AND 2) the requested drug will be used as subsequent therapy for any of the following: a) locally advanced, recurrent, or metastatic urothelial carcinoma, OR b) stage II-IV, recurrent, or persistent urothelial carcinoma of the bladder. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | BANZEL |
| ***Drug Names*** | RUFINAMIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 1 year of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | BENLYSTA |
| ***Drug Names*** | BENLYSTA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | For patients new to therapy: severe active central nervous system lupus. |
| ***Required Medical Information*** | For systemic lupus erythematosus (SLE): 1) patient is currently receiving a standard therapy regimen for SLE (for example, corticosteroid, antimalarial, or NSAIDs), OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for SLE, AND 3) for initial starts, patient has confirmed diagnosis of SLE from positive autoantibodies relevant to SLE (e.g., antinuclear antibodies [ANA], anti-double stranded DNA [anti-ds DNA], anti-Smith [anti-Sm], antiphospholipid antibodies, complement proteins). For lupus nephritis: 1) patient is currently receiving a standard therapy regimen for lupus nephritis (for example, corticosteroid, cyclophosphamide, mycophenolate mofetil, or azathioprine) OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for lupus nephritis, AND 3) for initial starts, patient has confirmed diagnosis of LN from either of the following: a) kidney biopsy, b) positive for autoantibodies relevant to SLE (e.g., antinuclear antibodies [ANA], anti-double stranded DNA [anti-ds DNA], anti-Smith [anti-Sm], antiphospholipid antibodies, complement proteins). |
| ***Age Restrictions*** | 5 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | BERINERT |
| ***Drug Names*** | BERINERT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For treatment of acute angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | Prescribed by or in consultation with an immunologist, allergist, or rheumatologist |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | BESREMI |
| ***Drug Names*** | BESREMI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | BETASERON |
| ***Drug Names*** | BETASERON |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | BEXAROTENE |
| ***Drug Names*** | BEXAROTENE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Mycosis fungoides (MF)/Sezary syndrome (SS), CD30-positive primary cutaneous anaplastic large cell lymphoma (ALCL), CD30-positive lymphomatoid papulosis (LyP), subcutaneous panniculitis-like T-cell lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | BIMZELX |
| ***Drug Names*** | BIMZELX |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): 1) Patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) Patient has a contraindication that would prohibit a trial of NSAIDs. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | BOSENTAN |
| ***Drug Names*** | BOSENTAN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) if the request is for an adult patient, the patient meets both of the following: a) pretreatment pulmonary vascular resistance is greater than 2 Wood units, and b) the patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to ambrisentan (Letairis). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | BOSULIF |
| ***Drug Names*** | BOSULIF |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Philadelphia chromosome positive B-cell acute lymphoblastic leukemia (Ph+ B-ALL), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I, G250E, V299L, and F317L, AND 3) Patient has experienced resistance or intolerance to imatinib, dasatinib, or nilotinib. For B-ALL including patients who have received hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I, G250E, V299L, and F317L. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | BRAFTOVI |
| ***Drug Names*** | BRAFTOVI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Adjuvant or neoadjuvant systemic therapy for cutaneous melanoma, appendiceal adenocarcinoma, recurrent NSCLC |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For colorectal cancer (including appendiceal adenocarcinoma): 1) Tumor is positive for BRAF V600E mutation, AND 2) The patient has either of the following: a) advanced or metastatic disease, b) unresectable metachronous metastases, AND 3) The requested drug will be used in combination with cetuximab or panitumumab. For melanoma: 1) Tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with binimetinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. For non-small cell lung cancer (NSCLC): 1) Tumor is positive for BRAF V600E mutation, AND 2) Disease is advanced, recurrent, or metastatic, AND 3) The requested drug will be used in combination with binimetinib. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | BRIVIACT |
| ***Drug Names*** | BRIVIACT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older). |
| ***Age Restrictions*** | 1 month of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | BRUKINSA |
| ***Drug Names*** | BRUKINSA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Hairy cell leukemia |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | BUPRENORPHINE PATCH |
| ***Drug Names*** | BUPRENORPHINE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | CABOMETYX |
| ***Drug Names*** | CABOMETYX |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-small cell lung cancer, Ewing sarcoma, osteosarcoma, gastrointestinal stromal tumor, endometrial carcinoma, soft tissue sarcoma (alveolar soft part sarcoma and extraskeletal myxoid chondrosarcoma subtypes) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For renal cell carcinoma: The disease is advanced, relapsed, or stage IV (including brain metastases). For non-small cell lung cancer: 1) the disease is rearranged during transfection (RET) positive AND 2) the disease is recurrent, advanced, or metastatic. For hepatocellular carcinoma: the requested drug will be used as subsequent therapy. For gastrointestinal stromal tumor (GIST): 1) the disease is residual, unresectable, recurrent, or metastatic/tumor rupture, AND 2) the disease has progressed after at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib). For Ewing sarcoma and osteosarcoma: the requested drug will be used as subsequent therapy. For differentiated thyroid cancer (DTC) (follicular, papillary, oncocytic): 1) the disease is locally advanced or metastatic, AND 2) the disease has progressed after a vascular endothelial growth factor receptor (VEGFR)- targeted therapy, AND 3) the patient is refractory to radioactive iodine therapy (RAI) or ineligible for RAI. For endometrial carcinoma: 1) the disease is recurrent, AND 2) the requested drug will be used as subsequent therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | CALCIPOTRIENE |
| ***Drug Names*** | CALCIPOTRIENE, CALCITRENE, ENSTILAR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For psoriasis: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a topical steroid. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | CALQUENCE |
| ***Drug Names*** | CALQUENCE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Waldenstrom macroglobulinemia (lymphoplasmacytic lymphoma), marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, and splenic marginal zone lymphoma): the requested drug is being used for the treatment of relapsed, refractory, or progressive disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | CAPRELSA |
| ***Drug Names*** | CAPRELSA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Thyroid carcinomas (follicular, oncocytic, papillary). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | CARBAGLU |
| ***Drug Names*** | CARGLUMIC ACID |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For all indications: Diagnosis confirmed by enzymatic, biochemical, or genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | CAYSTON |
| ***Drug Names*** | CAYSTON |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For treatment of respiratory symptoms in cystic fibrosis patients: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of pseudomonas aeruginosa infection or colonization in the airways. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | CEQUR |
| ***Drug Names*** | CEQUR SIMPLICITY 2U, CEQUR SIMPLICITY INSERTER |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Initial: 1) the patient has diabetes requiring insulin management AND 2) the patient is currently self-testing glucose levels, the patient will be counseled on self-testing glucose levels, or the patient is using a continuous glucose monitor AND 3) the patient meets either of the following: a) the patient has tried bolus injections and either did not meet glycemic goals or had difficulties administering multiple insulin injections daily, b) the patient is unable to try bolus injections. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | CERDELGA |
| ***Drug Names*** | CERDELGA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For type 1 Gaucher disease (GD1): 1) Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing, and 2) Patient's CYP2D6 metabolizer status has been established using an FDA-cleared test, and 3) Patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | CEREZYME |
| ***Drug Names*** | CEREZYME |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Type 2 Gaucher disease, Type 3 Gaucher disease |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For Gaucher disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | CGM LCD L33822 |
| ***Drug Names*** | DEXCOM G6 RECEIVER, DEXCOM G6 SENSOR, DEXCOM G6 TRANSMITTER, DEXCOM G7 RECEIVER, DEXCOM G7 SENSOR, FREESTYLE LIBRE 14 DAY/SE, FREESTYLE LIBRE 2/READER/, FREESTYLE LIBRE 2/SENSOR/, FREESTYLE LIBRE 3/READER/, FREESTYLE LIBRE 3/SENSOR/, FREESTYLE LIBRE/READER/FL |
| ***PA Indication Indicator*** | - |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | - |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | CLOBAZAM |
| ***Drug Names*** | CLOBAZAM |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Seizures associated with Dravet syndrome |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | Seizures associated with Lennox-Gastaut syndrome (LGS): 2 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | CLOMIPRAMINE |
| ***Drug Names*** | CLOMIPRAMINE HYDROCHLORID |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Depression, panic disorder |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For obsessive-compulsive disorder (OCD) and panic disorder: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to any of the following: a serotonin and norepinephrine reuptake inhibitor (SNRI), a selective serotonin reuptake inhibitor (SSRI). For depression: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to two of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. . For all indications: If the patient is 65 years of age or older AND is using one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, hydroxyzine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | CLORAZEPATE |
| ***Drug Names*** | CLORAZEPATE DIPOTASSIUM |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For all indications: 1) The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient(Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.), 2) if the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.] For the management of anxiety disorders: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Short-term relief anxiety-1 month, Anxiety Disorders-4 months, All other Diagnoses-Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | CLOZAPINE ODT |
| ***Drug Names*** | CLOZAPINE ODT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | COMETRIQ |
| ***Drug Names*** | COMETRIQ |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-small cell lung cancer (NSCLC), thyroid carcinomas (follicular, oncocytic, papillary). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): Disease is positive for rearranged during transfection (RET) rearrangements. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | COPIKTRA |
| ***Drug Names*** | COPIKTRA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Hepatosplenic T-Cell lymphoma, breast implant-associated anaplastic large cell lymphoma (ALCL), peripheral T-Cell lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), breast implant-associated anaplastic large cell lymphoma (ALCL), and peripheral T-Cell lymphoma: the patient has relapsed or refractory disease. For hepatosplenic T-Cell lymphoma: the patient has refractory disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | COTELLIC |
| ***Drug Names*** | COTELLIC |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Central nervous system (CNS) cancer (i.e., glioma, glioblastoma), adjuvant or neoadjuvant systemic therapy for cutaneous melanoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For central nervous system (CNS) cancer (i.e., glioma, glioblastoma): 1) The tumor is positive for BRAF V600E activating mutation, AND 2) The requested drug will be used in combination with vemurafenib. For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used in combination with vemurafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | CRESEMBA |
| ***Drug Names*** | CRESEMBA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Fluconazole-refractory esophageal candidiasis in a patient with HIV, fungal peritoneal dialysis-associated peritonitis |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug is being used orally. For invasive aspergillosis and fluconazole-refractory esophageal candidiasis in a patient with HIV: the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to voriconazole. |
| ***Age Restrictions*** | 6 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Invasive Aspergillosis: 3 mo. Invasive Mucormycosis: 6 mo. Esophageal candidiasis, peritonitis: 1 mo |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | CYSTADROPS |
| ***Drug Names*** | CYSTADROPS |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystinosis: 1) Diagnosis was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has corneal cystine crystal accumulation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | CYSTAGON |
| ***Drug Names*** | CYSTAGON |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For nephropathic cystinosis: Diagnosis was confirmed by ANY of the following: 1) the presence of increased cystine concentration in leukocytes, OR 2) genetic testing, OR 3) demonstration of corneal cystine crystals by slit lamp examination. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | CYSTARAN |
| ***Drug Names*** | CYSTARAN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystinosis: 1) Diagnosis was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has corneal cystine crystal accumulation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | DALFAMPRIDINE |
| ***Drug Names*** | DALFAMPRIDINE ER |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For multiple sclerosis (for new starts): prior to initiating therapy, patient demonstrates sustained walking impairment. For multiple sclerosis (continuation): patient must have experienced an improvement in walking speed OR other objective measure of walking ability since starting the requested drug. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | DANZITEN |
| ***Drug Names*** | DANZITEN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), pigmented villonodular synovitis/tenosynovial giant cell tumor |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I, Y253H, E255K/V, and F359V/C/I mutations. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If the patient has experienced resistance to an alternative tyrosine kinase inhibitor for ALL, patient is negative for T315I, Y253H, E255K/V, F359V/C/I and G250E mutations. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | DARAPRIM |
| ***Drug Names*** | PYRIMETHAMINE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Toxoplasmosis prophylaxis, Pneumocystis jirovecii pneumonia prophylaxis, cystoisosporiasis treatment and secondary prophylaxis |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For primary toxoplasmosis prophylaxis, Pneumocystis jirovecii pneumonia (PCP) prophylaxis, and secondary cystoisosporiasis prophylaxis: 1) The patient has experienced an intolerance or has a contraindication to trimethoprim-sulfamethoxazole (TMP-SMX) AND 2) The patient is immunocompromised. For secondary toxoplasmosis prophylaxis: The patient is immunocompromised. For cystoisosporiasis treatment: The patient has experienced an intolerance or has a contraindication to TMP-SMX. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Congen toxo tx: Plan Yr. Acqu toxo tx, prim toxo ppx, PCP ppx: 3mo. Sec toxo ppx, cysto tx/ppx: 6mo |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | DAURISMO |
| ***Drug Names*** | DAURISMO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Post-induction therapy/consolidation following response to previous therapy with the same regimen for acute myeloid leukemia (AML) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acute myeloid leukemia (AML): 1) the requested drug must be used in combination with cytarabine, 2) the patient is 75 years of age or older OR has comorbidities that preclude intensive chemotherapy, AND 3) the requested drug will be used as treatment for induction therapy or post-induction/consolidation therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | DEFERASIROX |
| ***Drug Names*** | DEFERASIROX |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | DEMSER |
| ***Drug Names*** | METYROSINE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to an alpha-adrenergic antagonist. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | DEXMETHYLPHENIDATE |
| ***Drug Names*** | DEXMETHYLPHENIDATE HCL, DEXMETHYLPHENIDATE HYDROC |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Cancer-related fatigue |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR 2) The requested drug is being prescribed for the treatment of cancer-related fatigue after other causes of fatigue have been ruled out. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | DHE NASAL |
| ***Drug Names*** | DIHYDROERGOTAMINE MESYLAT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin). |
| ***Required Medical Information*** | The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT1 receptor agonist. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | DIACOMIT |
| ***Drug Names*** | DIACOMIT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 6 months of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | DIAZEPAM |
| ***Drug Names*** | DIAZEPAM, DIAZEPAM INTENSOL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For all indications: 1) The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.), 2) if the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.]. For the management of anxiety disorders: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Short-term relief anx-1 mo, skeletal muscle spasm-3 mo, Anx Disorders-4 mo, Other Diagnoses-PlanYR |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. Applies to greater than cumulative 5 days of therapy per year. |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | DOPTELET |
| ***Drug Names*** | DOPTELET, DOPTELET SPRINKLE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For thrombocytopenia in patients with chronic liver disease: Untransfused platelet count prior to a scheduled procedure is less than 50,000/mcL. For chronic or persistent immune thrombocytopenia (ITP) (new starts): 1) Patient has experienced an inadequate treatment response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, AND 2) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000 to 50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma). For ITP (continuation): platelet count response to the requested drug: 1) Current platelet count is less than or equal to 200,000/mcL, OR 2) Current platelet count is greater than 200,000/mcL and less than or equal to 400,000/mcL and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding. |
| ***Age Restrictions*** | Chronic liver disease: 18 years of age or older, ITP: 1 year of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Chronic liver disease: 1 month, ITP initial: 6 months, ITP continuation: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | DRIZALMA |
| ***Drug Names*** | DRIZALMA SPRINKLE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Cancer pain, chemotherapy-induced neuropathic pain |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. For Generalized Anxiety Disorder, Diabetic Peripheral Neuropathy, Fibromyalgia, Chronic Musculoskeletal pain: 1) The patient has tried duloxetine capsules OR 2) The patient is unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration). |
| ***Age Restrictions*** | Generalized Anxiety Disorder: 7 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | DUPIXENT |
| ***Drug Names*** | DUPIXENT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For atopic dermatitis (AD), initial therapy: 1) Patient has moderate-to-severe disease, AND 2) At least 10% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, AND 3) Patient has had an inadequate treatment response to either a topical corticosteroid or a topical calcineurin inhibitor, OR topical corticosteroids and topical calcineurin inhibitors are not advisable for the patient. For AD, continuation of therapy: Patient achieved or maintained positive clinical response. For oral corticosteroid dependent asthma, initial therapy: Patient has inadequate asthma control despite current treatment with both of the following medications: 1) High-dose inhaled corticosteroid AND 2) Additional controller (i.e., long acting beta2-agonist (LABA), long-acting, muscarinic antagonist (LAMA), leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For moderate-to-severe asthma, initial therapy: Patient has a baseline blood eosinophil count of at least 150 cells per microliter and their asthma remains inadequately controlled despite current treatment with both of the following medications: 1) Medium-to-high-dose inhaled corticosteroid, AND 2) Additional controller (i.e., LABA, LAMA, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. |
| ***Age Restrictions*** | Atopic Dermatitis: 6 months of age or older, Asthma: 6 years of age or older, Chronic Rhinosinusitis with Nasal Polyposis and Chronic Spontaneous Urticaria: 12 years of age or older, Chronic Obstructive Pulmonary Disease, Bullous Pemphigoid, and Prurigo Nodularis: 18 years of age or older, Eosinophilic Esophagitis: 1 year of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | AD, PN, CSU initial: 6 months, AD cont, PN cont, CSU cont, All others: Plan Year |

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| ***Other Criteria*** | For chronic rhinosinusitis with nasal polyposis (CRSwNP): 1) The requested drug is used as add-on maintenance treatment, AND 2) For 18 years of age or older, patient has experienced an inadequate treatment response to Xhance (fluticasone). For eosinophilic esophagitis (EoE), initial therapy: 1) Diagnosis has been confirmed by esophageal biopsy characterized by greater than or equal to 15 intraepithelial esophageal eosinophils per high power field, AND 2) Patient is exhibiting clinical manifestations of the disease (for example, dysphagia), AND 3) Patient weighs at least 15 kilograms, AND 4) Patient experienced an inadequate treatment response, intolerance, or patient has a contraindication to a topical corticosteroid. For EoE, continuation of therapy: Patient achieved or maintained a positive clinical response. For prurigo nodularis (PN), continuation of therapy: Patient achieved or maintained a positive clinical response. For chronic obstructive pulmonary disease (COPD), initial therapy: 1) Patient is either of the following: a) currently receiving standard inhaled triple therapy (i.e., inhaled glucocorticoid, LAMA, and LABA) or b) currently receiving a LAMA and LABA, and has a contraindication to inhaled glucocorticoid, AND 2) Patient has an absolute blood eosinophil count of at least 300 cells per microliter prior to initiating therapy. For COPD, continuation of therapy: Patient achieved or maintained a positive clinical response. For chronic spontaneous urticaria (CSU), initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and interleukin-1 (IL-1)-associated urticarial syndromes (e.g., auto-inflammatory disorders, urticarial vasculitis), AND 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks, AND 3) Patient remains symptomatic despite H1 antihistamine treatment. For CSU, continuation of therapy: Patient has experienced a benefit (e.g., improved symptoms) since initiation of therapy. For bullous pemphigoid (BP), initial therapy: 1) Diagnosis has been confirmed by direct immunofluorescence study OR immune serological test(s), AND 2) Patient exhibits clinical manifestations of the disease (e.g., bullous lesions, excoriations, eczematous and/or urticarial erythematous lesions), AND 3) Prior to initiation with the requested drug the patient has had an inadequate treatment response to either a high-potency topical corticosteroid or systemic corticosteroid OR high-potency topical corticosteroids and systemic corticosteroids are not advisable for the patient. For BP, continuation of therapy: Patient achieved or maintained a positive clinical response. |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | ELIGARD |
| ***Drug Names*** | ELIGARD |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Salivary gland tumors |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For salivary gland tumors: 1) the disease is androgen receptor positive AND 2) the disease is recurrent, metastatic, or unresectable. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | EMGALITY |
| ***Drug Names*** | EMGALITY |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline. For episodic cluster headache, initial: The patient experienced an inadequate treatment response, intolerance, or contraindication to a triptan 5-HT1 receptor agonist. For episodic cluster headache, continuation: The patient received the requested drug for at least 3 weeks of treatment and had a reduction in weekly cluster headache attack frequency from baseline. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial: 3 months, Continuation: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | EMSAM |
| ***Drug Names*** | EMSAM |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For Major Depressive Disorder (MDD): 1) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion, OR 2) The patient is unable to swallow oral formulations. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | ENDARI |
| ***Drug Names*** | L-GLUTAMINE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 5 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ENSACOVE |
| ***Drug Names*** | ENSACOVE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): 1) The patient has recurrent, advanced, or metastatic disease, AND 2) The disease is anaplastic lymphoma kinase (ALK)-positive, AND 3) The patient has not previously received an ALK-inhibitor, OR the patient has experienced intolerance or disease progression with crizotinib. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | EPCLUSA |
| ***Drug Names*** | EPCLUSA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Criteria will be applied consistent with current AASLD-IDSA guidance |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | EPIDIOLEX |
| ***Drug Names*** | EPIDIOLEX |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 1 year of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | EPRONTIA |
| ***Drug Names*** | TOPIRAMATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older). For monotherapy treatment of primary generalized tonic-clonic seizures: 1) The patient has tried a generic topiramate immediate release product, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) If the patient is 6 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam. For the preventative treatment of migraines: 1) The patient has tried a generic topiramate immediate release product, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). |
| ***Age Restrictions*** | Epilepsy: 2 years of age or older, Migraine: 12 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | ERGOTAMINE |
| ***Drug Names*** | ERGOTAMINE TARTRATE/CAFFE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin). |
| ***Required Medical Information*** | The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT1 agonist. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | ERIVEDGE |
| ***Drug Names*** | ERIVEDGE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Adult medulloblastoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For adult medulloblastoma: patient has received prior systemic therapy AND has tumor(s) with mutations in the sonic hedgehog pathway. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | ERLEADA |
| ***Drug Names*** | ERLEADA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | ERLOTINIB |
| ***Drug Names*** | ERLOTINIB HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent non-small cell lung cancer (NSCLC), recurrent chordoma, relapsed or stage IV renal cell carcinoma (RCC), brain metastases from non-small cell lung cancer (NSCLC), recurrent pancreatic cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC) (including brain metastases from NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease. For pancreatic cancer: the disease is locally advanced, unresectable, recurrent, or metastatic. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | ESBRIET |
| ***Drug Names*** | PIRFENIDONE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For idiopathic pulmonary fibrosis (new starts only): 1) other causes of pulmonary fibrosis have been excluded, AND 2) the patient meets one of the following: a) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR b) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | ETANERCEPT |
| ***Drug Names*** | ENBREL, ENBREL MINI, ENBREL SURECLICK |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Hidradenitis suppurativa, non-radiographic axial spondyloarthritis |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active rheumatoid arthritis (new starts only): 1) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) Patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): 1) Patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) The patient has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | EUCRISA |
| ***Drug Names*** | EUCRISA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For mild to moderate atopic dermatitis, the patient meets either of the following criteria: 1) If the patient is 2 years of age or older and the requested drug will be used on sensitive skin areas (e.g., face, genitals, or skin folds), the patient has experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor OR 2) If the patient is 2 years of age or older and the requested drug is being prescribed for use on non-sensitive (or remaining) skin areas, the patient has experienced an inadequate treatment response, intolerance, or contraindication to a medium or higher potency topical corticosteroid or a topical calcineurin inhibitor. |
| ***Age Restrictions*** | 3 months of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | EVEROLIMUS |
| ***Drug Names*** | EVEROLIMUS, TORPENZ |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Classic Hodgkin lymphoma, thymomas and thymic carcinomas, previously treated Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma (perivascular epithelioid cell tumors (PEComa) and lymphangioleiomyomatosis subtypes), gastrointestinal stromal tumors, neuroendocrine tumors of the thymus, well differentiated grade 3 neuroendocrine tumors, thyroid carcinoma (papillary, oncocytic, and follicular), endometrial carcinoma, uterine sarcoma, breast cancer (in combination with fulvestrant or tamoxifen), histiocytic neoplasms (Rosai-Dorfman Disease, Erdheim-Chester Disease, Langerhans Cell Histiocytosis), meningiomas. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For breast cancer: 1) The disease is recurrent unresectable, advanced, or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, AND 2) The requested drug is prescribed in combination with exemestane, fulvestrant, or tamoxifen, AND 3) The requested drug is used for subsequent treatment. For renal cell carcinoma: The disease is relapsed, advanced, or stage IV. For subependymal giant cell astrocytoma (SEGA): The requested drug is given as adjuvant treatment. For gastrointestinal stromal tumor: 1) The disease is residual, recurrent, unresectable, or metastatic/tumor rupture, AND 2) The disease has progressed after use of at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib). For Erdheim-Chester Disease (ECD), Rosai-Dorfman Disease, and Langerhans Cell Histiocytosis (LCH): the patient must have a phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | EXXUA |
| ***Drug Names*** | EXXUA, EXXUA TITRATION PACK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | FABRAZYME |
| ***Drug Names*** | FABRAZYME |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For Fabry disease, the patient meets ANY of the following: 1) Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, OR 2) The patient is a symptomatic obligate carrier. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | FANAPT |
| ***Drug Names*** | FANAPT, FANAPT TITRATION PACK A, FANAPT TITRATION PACK B, FANAPT TITRATION PACK C |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For treatment of schizophrenia: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Lybalvi, Caplyta, Rexulti, Secuado, Vraylar. For acute treatment of manic or mixed episodes associated with bipolar I disorder: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Lybalvi, Vraylar. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | FASENRA |
| ***Drug Names*** | FASENRA, FASENRA PEN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For severe asthma, initial therapy: 1) Either a) Patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) Patient is dependent on systemic corticosteroids, AND 2) Patient has a history of severe asthma despite current treatment with both of the following medications: a) medium-to-high-dose inhaled corticosteroid AND b) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline), unless patient has an intolerance or contraindication to such therapies. For severe asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For eosinophilic granulomatosis with polyangiitis (EGPA), initial therapy: patient has a history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level of greater than 10 percent. For EGPA, continuation of therapy: patient has a beneficial response to treatment with the requested drug, as demonstrated by any of the following: 1) a reduction in the frequency of relapses, 2) a reduction in the daily oral corticosteroid dose, OR 3) no active vasculitis. |
| ***Age Restrictions*** | Asthma: 6 years of age or older, EGPA: 18 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | FEBUXOSTAT |
| ***Drug Names*** | FEBUXOSTAT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | FENTANYL PATCH |
| ***Drug Names*** | FENTANYL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | FETZIMA |
| ***Drug Names*** | FETZIMA, FETZIMA TITRATION PACK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | FINTEPLA |
| ***Drug Names*** | FINTEPLA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 2 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | FIRMAGON |
| ***Drug Names*** | FIRMAGON |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | FLUCYTOSINE |
| ***Drug Names*** | FLUCYTOSINE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | fungal peritoneal dialysis-associated peritonitis |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Peritonitis: 1 month, Candida: 6 weeks, Cryptococcus: 6 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | FORM ALT PA CLINDAMYCIN |
| ***Drug Names*** | CLINDAMYCIN PHOSPHATE (ON |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The patient has experienced an intolerance to one of the following formulary products: clindamycin lotion, clindamycin topical solution, clindamycin gel (twice daily). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | FOTIVDA |
| ***Drug Names*** | FOTIVDA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For renal cell carcinoma: 1) The disease is advanced, relapsed, refractory or Stage IV, AND 2) The patient has received two or more prior systemic therapies. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | FRUZAQLA |
| ***Drug Names*** | FRUZAQLA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Appendiceal adenocarcinoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For colorectal cancer and appendiceal adenocarcinoma: 1) the disease is advanced or metastatic, AND 2) the requested drug will be used as a single agent, AND 3) the requested drug will be used as a second line or subsequent therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | FULPHILA |
| ***Drug Names*** | FULPHILA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Stem cell transplantation-related indications |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | FYCOMPA |
| ***Drug Names*** | FYCOMPA, PERAMPANEL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri, Spritam. For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam. |
| ***Age Restrictions*** | Partial-onset seizures (i.e., focal-onset seizures): 4 years of age or older. Primary generalized tonic-clonic seizures: 12 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | GATTEX |
| ***Drug Names*** | GATTEX |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For short bowel syndrome (SBS) initial therapy: the patient is dependent on parenteral support. For SBS continuation: requirement for parenteral support has decreased from baseline while on therapy with the requested drug. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | Prescribed by or in consultation with a gastroenterologist, gastrointestinal surgeon, or nutritional support specialist |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | GAVRETO |
| ***Drug Names*** | GAVRETO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent rearranged during transfection (RET) rearrangement-positive non-small cell lung cancer, RET gene fusion positive gallbladder cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced, or metastatic, AND 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement-positive. |
| ***Age Restrictions*** | Non-small cell lung cancer: 18 years of age or older, Thyroid cancer: 12 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | GILENYA |
| ***Drug Names*** | FINGOLIMOD HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | GILOTRIF |
| ***Drug Names*** | GILOTRIF |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For epidermal growth factor receptor (EGFR)-positive non-small cell lung cancer (NSCLC): 1) The disease is recurrent, advanced, or metastatic, AND 2) The patient has experienced an intolerable adverse event or contraindication to erlotinib, gefitinib, or osimertinib. For metastatic squamous NSCLC: The disease has progressed after platinum-based chemotherapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | GLATIRAMER |
| ***Drug Names*** | COPAXONE, GLATIRAMER ACETATE, GLATOPA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | GOMEKLI |
| ***Drug Names*** | GOMEKLI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 2 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | GROWTH HORMONE |
| ***Drug Names*** | GENOTROPIN, GENOTROPIN MINIQUICK |
| ***PA Indication Indicator*** | All Medically-accepted Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Pediatric patients with closed epiphyses |
| ***Required Medical Information*** | Pediatric growth hormone deficiency (GHD): Patient (pt) is a neonate or was diagnosed with GHD as a neonate OR meets any of the following: 1) younger than 2.5 years old (yo) with pre-treatment (pre-tx) height (ht) more than 2 standard deviations (SD) below mean and slow growth velocity OR 2) 2.5 yo or older AND one of the following: a) pre-tx 1-year ht velocity more than 2 SD below mean OR b) pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean, AND patient meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), OR 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean. Turner syndrome (TS): 1) Confirmed by karyotyping AND 2) pre-tx ht is less than the 5th percentile for age. Small for gestational age (SGA): 1) Birth weight (wt) less than 2500g at gestational age (GA) greater than 37 weeks, OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) did not manifest catch-up growth by age 2. |
| ***Age Restrictions*** | SGA: 2 years of age or older |
| ***Prescriber Restrictions*** | Prescribed by or in consultation with an endocrinologist, nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, or geneticist |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Adult GHD: Pt meets any of the following: 1) failed 2 pre-tx GH stimulation tests, OR 2) pre-tx IGF-1 more than 2 SD below mean AND failed 1 pre-tx GH stimulation test, OR 3) organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with 3 or more pituitary hormone deficiencies AND pre-tx IGF-1 more than 2 SD below mean, OR 4) genetic or structural hypothalamic-pituitary defects, OR 5) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS. For pediatric GHD, TS, SGA, and adult GHD, continuation of therapy: Patient is experiencing improvement. |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | HADLIMA |
| ***Drug Names*** | ADALIMUMAB-BWWD, HADLIMA, HADLIMA PUSHTOUCH |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-radiographic axial spondyloarthritis, Behcet's disease |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | For non-infectious intermediate, posterior and panuveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a corticosteroid OR 2) pt has a contraindication that would prohibit a trial of corticosteroids. |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | HAEGARDA |
| ***Drug Names*** | HAEGARDA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the prophylaxis of angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month. |
| ***Age Restrictions*** | 6 years of age or older |
| ***Prescriber Restrictions*** | Prescribed by or in consultation with an immunologist, allergist, or rheumatologist |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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| ***Prior Authorization Group*** | HERCEPTIN |
| ***Drug Names*** | HERCEPTIN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | HERCEPTIN HYLECTA |
| ***Drug Names*** | HERCEPTIN HYLECTA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | No |

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| ***Prior Authorization Group*** | HERCESSI |
| ***Drug Names*** | HERCESSI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | HERNEXEOS |
| ***Drug Names*** | HERNEXEOS |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent non-small cell lung cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): 1) The disease is positive for human epidermal growth factor receptor 2 (HER2) (erythroblastic oncogene B [ERBB2]) mutations AND 2) The disease is recurrent, advanced, unresectable, or metastatic AND 3) The patient has received a prior systemic therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | HERZUMA |
| ***Drug Names*** | HERZUMA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | HETLIOZ |
| ***Drug Names*** | TASIMELTEON |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For Non-24-Hour Sleep-Wake Disorder: 1) For initial therapy and continuation of therapy, the patient must meet both of the following: a) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and b) unable to perceive light in either eye, AND 2) If currently on therapy with the requested drug, patient must meet at least one of the following: a) increased total nighttime sleep or b) decreased daytime nap duration. For nighttime sleep disturbances in Smith-Magenis Syndrome (SMS): 1) For initial therapy and continuation therapy, the patient has a confirmed diagnosis of SMS, AND 2) If currently on therapy with the requested drug, the patient experienced improvement in the quality of sleep since starting therapy. |
| ***Age Restrictions*** | Non-24: 18 years of age or older, SMS: 16 years of age or older |
| ***Prescriber Restrictions*** | Prescribed by or in consultation with a sleep disorder specialist, neurologist, or psychiatrist |
| ***Coverage Duration*** | Initial: 6 months, Continuation: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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| ***Prior Authorization Group*** | HIGH RISK MEDICATION |
| ***Drug Names*** | DIPYRIDAMOLE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |
| ***Prerequisite Therapy Required*** | No |

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| ***Prior Authorization Group*** | HRM-AMITRIPTYLINE |
| ***Drug Names*** | AMITRIPTYLINE HCL, AMITRIPTYLINE HYDROCHLORI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Neuropathic pain, chronic tension-type headache prophylaxis, chronic neck pain |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | HRM-ANTICONVULSANTS |
| ***Drug Names*** | PHENOBARBITAL, PHENOBARBITAL SODIUM |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Epilepsy |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |
| ***Prerequisite Therapy Required*** | No |

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| ***Prior Authorization Group*** | HRM-ANTIPARKINSON |
| ***Drug Names*** | BENZTROPINE MESYLATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | EPS (extrapyramidal symptoms): 1) The patient has not tried the non-HRM alternative drug amantadine AND 2) The patient has a contraindication to the non-HRM alternative drug amantadine OR 3) The patient has tried the non-HRM alternative drug amantadine AND 4) The patient experienced an inadequate treatment response OR intolerance to the non-HRM alternative drug amantadine. Parkinson's: 1) The patient has tried two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | HRM-CYPROHEPTADINE |
| ***Drug Names*** | CYPROHEPTADINE HCL, CYPROHEPTADINE HYDROCHLOR |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Pruritus, spasticity due to spinal cord injury |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.). Prior Authorization applies to greater than cumulative 30 days of therapy per year. |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | HRM-DOXEPIN |
| ***Drug Names*** | DOXEPIN HCL, DOXEPIN HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone. For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | HRM-GUANFACINE ER |
| ***Drug Names*** | GUANFACINE HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |
| ***Prerequisite Therapy Required*** | No |

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| ***Prior Authorization Group*** | HRM-GUANFACINE IR |
| ***Drug Names*** | GUANFACINE HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |
| ***Prerequisite Therapy Required*** | No |

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| ***Prior Authorization Group*** | HRM-HYDROXYZINE |
| ***Drug Names*** | HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE, HYDROXYZINE PAMOATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release OR 3) The patient has not tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 4) The patient has acute anxiety. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.). Prior authorization applies to greater than cumulative 30 days of therapy per year. |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | HRM-HYDROXYZINE INJ |
| ***Drug Names*** | HYDROXYZINE HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For Alcohol Withdrawal Syndrome: 1) The patient has not tried one of the following alternative drugs: clorazepate or lorazepam AND 2) The patient has a contraindication to one of the following alternative drugs: clorazepate or lorazepam OR 3) The patient has tried one of the following alternative drugs: clorazepate or lorazepam AND 4) The patient experienced an inadequate treatment response OR intolerance to one of the following alternative drugs: clorazepate or lorazepam. For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release OR 3) The patient has not tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 4) The patient has acute anxiety. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | HRM-HYPNOTICS |
| ***Drug Names*** | ZOLPIDEM TARTRATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For insomnia: 1) The patient meets one of the following: a) the patient has a contraindication to the non-HRM (non-High Risk Medication) alternative drugs doxepin (3 mg or 6 mg) and ramelteon OR b) The patient has tried one of the following non-HRM (non-High Risk Medication) alternative drugs: doxepin (3 mg or 6 mg) or ramelteon AND the patient experienced an inadequate treatment response OR intolerance to one of the following non-HRM (non-High Risk Medication) alternative drugs: doxepin (3 mg or 6 mg) or ramelteon AND 2) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient AND 3) If the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.]. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 90 days of therapy per year. |
| ***Prerequisite Therapy Required*** | Yes |

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| ***Prior Authorization Group*** | HRM-MECLIZINE |
| ***Drug Names*** | MECLIZINE HCL, MECLIZINE HYDROCHLORIDE |
| ***PA Indication Indicator*** | All Medically-accepted Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 30 days of therapy per year. |
| ***Prerequisite Therapy Required*** | No |

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| ***Prior Authorization Group*** | HRM-PROMETHAZINE |
| ***Drug Names*** | PROMETHAZINE HCL, PROMETHAZINE HYDROCHLORID |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.). Prior authorization applies to greater than cumulative 30 days of therapy per year. |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | HRM-SKELETAL MUSCLE RELAXANTS |
| ***Drug Names*** | CARISOPRODOL, CYCLOBENZAPRINE HYDROCHLO, METHOCARBAMOL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient AND 2) If the patient is using one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, hydroxyzine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 90 days of therapy per year. |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | HRM-TCA NEUROPATHIC PAIN |
| ***Drug Names*** | DESIPRAMINE HYDROCHLORIDE, IMIPRAMINE HCL, IMIPRAMINE HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Neuropathic pain |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | HUMIRA |
| ***Drug Names*** | HUMIRA, HUMIRA PEN, HUMIRA PEN-CD/UC/HS START, HUMIRA PEN-PS/UV STARTER |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-radiographic axial spondyloarthritis, Behcet's disease |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | For non-infectious intermediate, posterior and panuveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a corticosteroid OR 2) pt has a contraindication that would prohibit a trial of corticosteroids. |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | HYRNUO |
| ***Drug Names*** | HYRNUO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent non-small cell lung cancer (NSCLC) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer: 1) The disease is positive for human epidermal growth factor receptor 2 (HER2) (erythroblastic oncogene B [ERBB2]) mutations, AND 2) The disease is recurrent, advanced, or metastatic, AND 3) The requested drug will be used as subsequent therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | IBRANCE |
| ***Drug Names*** | IBRANCE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Unresectable well-differentiated/dedifferentiated liposarcoma of the retroperitoneum, recurrent hormone receptor-positive human epidermal growth factor receptor 2 (HER2)-negative breast cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For breast cancer: 1) the disease is advanced, recurrent, or metastatic, AND 2) the patient has hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative disease, AND 3) the patient meets ONE of the following: a) the requested drug will be used in combination with an aromatase inhibitor or fulvestrant, AND the patient has experienced an intolerable adverse event or has a contraindication to Kisqali (ribociclib) or Verzenio (abemaciclib), OR b) the patient is endocrine-resistant, PIK3CA-mutated, AND the requested drug will be used in combination with inavolisib and fulvestrant. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | IBTROZI |
| ***Drug Names*** | IBTROZI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ICATIBANT |
| ***Drug Names*** | ICATIBANT ACETATE, SAJAZIR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the treatment of acute angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month. |
| ***Age Restrictions*** | 18 years of age or older |
| ***Prescriber Restrictions*** | Prescribed by or in consultation with an immunologist, allergist, or rheumatologist |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ICLUSIG |
| ***Drug Names*** | ICLUSIG |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Myeloid and/or lymphoid neoplasms with eosinophilia and FGFR1 or ABL1 rearrangement in the chronic phase or blast phase, Gastrointestinal Stromal Tumors |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: 1) Patient has accelerated or blast phase CML and no other kinase inhibitor is indicated, OR 2) Patient has chronic phase CML and has experienced resistance or intolerance to at least 2 prior kinase inhibitors AND at least one of those was imatinib, dasatinib, or nilotinib, OR 3) Patient is positive for the T315I mutation, OR 4) Patient has no identifiable BCR-ABL1 mutation and resistance to primary therapy with imatinib, bosutinib, dasatinib, or nilotinib. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For gastrointestinal stromal tumors (GIST): 1) Disease meets any of the following: A) residual, B) unresectable, C) recurrent, D) metastatic/tumor rupture, AND 2) Disease has progressed after use of at least two Food and Drug Administration (FDA) approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | IDHIFA |
| ***Drug Names*** | IDHIFA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Newly-diagnosed acute myeloid leukemia |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation: 1) patient has newly-diagnosed AML and is not a candidate for or declines intensive induction therapy, OR 2) the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML, OR 4) the requested drug will be used as consolidation therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | IMATINIB |
| ***Drug Names*** | IMATINIB MESYLATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), recurrent chordoma, cutaneous melanoma, Kaposi sarcoma, chronic graft versus host disease (cGVHD), T-cell acute lymphoblastic leukemia with ABL-class translocation, aggressive systemic mastocytosis for well-differentiated systemic mastocytosis (WDSM) or when eosinophilia is present with FIP1L1-PDGFRA fusion gene, myeloid and/or lymphoid neoplasms with eosinophilia and ABL1, FIP1L1-PDGFRA, or PDGFRB rearrangement in the chronic phase or blast phase |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant: Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: Patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For cutaneous melanoma: 1) Disease is metastatic or unresectable AND 2) Disease is positive for c-KIT activating mutations AND 3) Requested medication will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | IMBRUVICA |
| ***Drug Names*** | IMBRUVICA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Hairy cell leukemia, lymphoplasmacytic lymphoma, primary central nervous system (CNS) lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphoma, diffuse large B-cell lymphoma, post-transplant lymphoproliferative disorders, high-grade B-cell lymphoma, mantle cell lymphoma, marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma), brain metastases in lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For mantle cell lymphoma: 1) the requested drug will be used as subsequent therapy OR 2) the requested drug will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (rituximab, cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen, OR 3) the requested drug will be used as aggressive induction therapy. For marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, and splenic marginal zone lymphoma): the requested drug will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary CNS lymphoma: 1) the disease is relapsed or refractory OR 2) the requested drug is used for induction therapy as a single agent. For diffuse large B-cell lymphoma, high-grade B-cell lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphoma: The requested drug will be used as a single agent and as second-line or subsequent therapy for relapsed or refractory disease. For post-transplant lymphoproliferative disorders: the requested drug will be used in patients who have received prior chemoimmunotherapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | IMKELDI |
| ***Drug Names*** | IMKELDI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent chordoma, cutaneous melanoma, Kaposi sarcoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For all indications: The patient is unable to use imatinib tablets. For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant: Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: Patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For cutaneous melanoma: 1) Disease is metastatic or unresectable AND 2) Disease is positive for c-KIT activating mutations AND 3) Requested medication will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | IMPAVIDO |
| ***Drug Names*** | IMPAVIDO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Pregnancy. Sjogren-Larsson-Syndrome. |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 12 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 28 days |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | INBRIJA |
| ***Drug Names*** | INBRIJA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For initial treatment of off episodes in Parkinson's disease: 1) The patient is currently being treated with oral carbidopa/levodopa, AND 2) The patient does not have any of the following: asthma, chronic obstructive pulmonary disease (COPD), or other chronic underlying lung disease. For continuation treatment of off episodes in Parkinson's disease: The patient is experiencing improvement on the requested drug. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | INCRELEX |
| ***Drug Names*** | INCRELEX |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Pediatric patients with closed epiphyses |
| ***Required Medical Information*** | For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone (GH) gene deletion in patients who have developed neutralizing antibodies to GH, patient meets all of the following prior to beginning therapy with the requested drug (new starts only): 1) height 3 or more standard deviations (SD) below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more SD below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level. For growth failure due to severe primary IGF-1 deficiency or GH gene deletion in patients who have developed neutralizing antibodies to GH, continuation of therapy: patient is experiencing improvement. |
| ***Age Restrictions*** | 2 years of age or older |
| ***Prescriber Restrictions*** | Prescribed by or in consultation with an endocrinologist |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | INLURIYO |
| ***Drug Names*** | INLURIYO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | INLYTA |
| ***Drug Names*** | INLYTA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Thyroid carcinoma (papillary, oncocytic, or follicular), alveolar soft part sarcoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For renal cell carcinoma: the disease is advanced, relapsed, or Stage IV. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | INQOVI |
| ***Drug Names*** | INQOVI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | INREBIC |
| ***Drug Names*** | INREBIC |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and janus kinase 2 (JAK2) rearrangement, accelerated or blast phase myeloproliferative neoplasms |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | INSULIN SUPPLIES |
| ***Drug Names*** | - |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested product is being used with insulin. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | IR BEFORE ER |
| ***Drug Names*** | HYDROCODONE BITARTRATE ER, METHADONE HCL, METHADONE HYDROCHLORIDE, METHADONE HYDROCHLORIDE I, MORPHINE SULFATE ER, OXYCONTIN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | IRESSA |
| ***Drug Names*** | GEFITINIB |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ISOTRETINOIN |
| ***Drug Names*** | ACCUTANE, AMNESTEEM, CLARAVIS, ISOTRETINOIN, ZENATANE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Severe acne vulgaris, severe refractory rosacea, neuroblastoma, cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), high risk for developing skin cancer (squamous cell cancers), transient acantholytic dermatosis (Grover's Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, pityriasis rubra pilaris |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | ITOVEBI |
| ***Drug Names*** | ITOVEBI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For breast cancer, the patient meets all of the following: a) the disease is recurrent, locally advanced, or metastatic, b) the disease is hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, and PIK3CA-mutated, c) the requested drug will be used in combination with fulvestrant and palbociclib, d) the patient has experienced disease progression, relapse, or recurrence on or after completing adjuvant endocrine therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | IVERMECTIN TAB |
| ***Drug Names*** | IVERMECTIN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Ascariasis, Cutaneous larva migrans, Mansonelliasis, Scabies, Gnathostomiasis, Pediculosis |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug is not being prescribed for the prevention or treatment of coronavirus disease 2019 (COVID-19). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 1 month |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | IVIG |
| ***Drug Names*** | ALYGLO, BIVIGAM, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD LIQUID ERC, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PANZYGA, PRIVIGEN |
| ***PA Indication Indicator*** | All Medically-accepted Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For B-cell chronic lymphocytic leukemia (CLL): 1) serum IgG less than 500 mg/dL OR 2) a history of recurrent bacterial infections. For bone marrow transplant/hematopoietic stem cell transplant (BMT/HSCT): 1) IVIG is requested within the first 100 days post-transplant OR 2) serum IgG less than 400 mg/dL. For pediatric human immunodeficiency virus (HIV) infection: 1) serum IgG less than 400 mg/dL OR 2) history of recurrent bacterial infections. For dermatomyositis and polymyositis: 1) at least one standard first-line treatment (corticosteroid or immunosuppressant) has been tried but was unsuccessful or not tolerated OR 2) patient is unable to receive standard therapy because of a contraindication or other clinical reason. For pure red cell aplasia (PRCA): PRCA is secondary to parvovirus B19 infection. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | IWILFIN |
| ***Drug Names*** | IWILFIN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | JAKAFI |
| ***Drug Names*** | JAKAFI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Lower-risk myelofibrosis, accelerated or blast phase myeloproliferative neoplasms, acute lymphoblastic leukemia (ALL), chronic myelomonocytic leukemia (CMML)-2, myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia, essential thrombocythemia, myeloid, lymphoid or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement, T-cell prolymphocytic leukemia, T-cell large granular lymphocytic leukemia |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For polycythemia vera: 1) patient has an inadequate response, intolerance, or resistance to hydroxyurea AND 2) patient meets ONE of the following: a) patient has an inadequate response or intolerance to Besremi (ropeginterferon alfa-2b-njft), OR b) patient has high risk disease. For acute lymphoblastic leukemia: patient has a cytokine receptor-like factor 2 (CRLF2) mutation or a mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway. For CMML-2: the requested drug is used in combination with a hypomethylating agent. For myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia: the requested drug is used as a single agent or in combination with a hypomethylating agent. For essential thrombocythemia: patient had an inadequate response or loss of response to hydroxyurea, interferon therapy, or anagrelide. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | JAYPIRCA |
| ***Drug Names*** | JAYPIRCA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL): The patient has received prior treatment with a Bruton Tyrosine Kinase (BTK) inhibitor, for example Calquence (acalabrutinib) or Brukinsa (zanubrutinib). For mantle cell lymphoma: the patient has received prior treatment with a BTK inhibitor, for example Calquence (acalabrutinib) or Brukinsa (zanubrutinib). For marginal zone lymphoma (MZL): the patient has received a covalent Bruton Tyrosine Kinase (BTK) inhibitor, for example, Calquence (acalabrutinib) or Brukinsa (zanubrutinib). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | JYNARQUE |
| ***Drug Names*** | TOLVAPTAN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | KALYDECO |
| ***Drug Names*** | KALYDECO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystic fibrosis: the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor). |
| ***Age Restrictions*** | 1 month of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | KANJINTI |
| ***Drug Names*** | KANJINTI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | KESIMPTA |
| ***Drug Names*** | KESIMPTA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | KETOCONAZOLE |
| ***Drug Names*** | KETOCONAZOLE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Cushing's syndrome |
| ***Exclusion Criteria*** | Acute or chronic liver disease. Concurrent use with drugs that are contraindicated with ketoconazole tablets: dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, irinotecan, lurasidone, oral midazolam, alprazolam, triazolam, felodipine, nisoldipine, tolvaptan, eplerenone, lovastatin, simvastatin, or colchicine. |
| ***Required Medical Information*** | The potential benefits outweigh the risks of treatment with oral ketoconazole. For systemic fungal infections, the patient has any of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis. For Cushing's syndrome: the requested drug is being prescribed for a patient who cannot tolerate surgery or where surgery has not been curative. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | KEYTRUDA |
| ***Drug Names*** | KEYTRUDA |
| ***PA Indication Indicator*** | All Medically-accepted Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | KEYTRUDA QLEX |
| ***Drug Names*** | KEYTRUDA QLEX |
| ***PA Indication Indicator*** | All Medically-accepted Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | KINERET |
| ***Drug Names*** | KINERET |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Systemic juvenile idiopathic arthritis, adult-onset Still's disease, multicentric Castleman's disease, Schnitzler syndrome, Erdheim-Chester disease. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active rheumatoid arthritis (new starts only): The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib-extended release). For active systemic juvenile idiopathic arthritis (new starts only): The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Tyenne (tocilizumab-aazg). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | KISQALI |
| ***Drug Names*** | KISQALI, KISQALI FEMARA 400 DOSE, KISQALI FEMARA 600 DOSE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer, in combination with an aromatase inhibitor, or fulvestrant. Endometrial cancer, in combination with letrozole, for estrogen receptor positive tumors |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | KOMZIFTI |
| ***Drug Names*** | KOMZIFTI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | KORLYM |
| ***Drug Names*** | MIFEPRISTONE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | Prescribed by or in consultation with an endocrinologist |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | KOSELUGO |
| ***Drug Names*** | KOSELUGO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | BRAF fusion or BRAF V600E activating mutation-positive recurrent or progressive circumscribed glioma, Langerhans cell histiocytosis |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | For neurofibromatosis type 1: 1 year of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | KRAZATI |
| ***Drug Names*** | KRAZATI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent KRAS G12C-positive non-small cell lung cancer (NSCLC), Central nervous system (CNS) brain metastases from KRAS G12C-positive NSCLC, KRAS G12C-positive pancreatic adenocarcinoma, KRAS G12C-positive ampullary adenocarcinoma, KRAS G12C-positive appendiceal adenocarcinoma, KRAS G12C-positive Biliary Tract Cancer (intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma, gall bladder cancer) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | LAPATINIB |
| ***Drug Names*** | LAPATINIB DITOSYLATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Brain metastases from human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, recurrent epidermal growth factor receptor (EGFR)-positive chordoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For breast cancer, the patient meets all the following: a) the disease is recurrent, advanced, or metastatic (including brain metastases), b) the disease is human epidermal growth factor receptor 2 (HER2)-positive, c) the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab. For colorectal cancer: 1) requested drug will be used in combination with trastuzumab and 2) patient has not had previous treatment with a HER2 inhibitor. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | LAZCLUZE |
| ***Drug Names*** | LAZCLUZE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | LENVIMA |
| ***Drug Names*** | LENVIMA 10 MG DAILY DOSE, LENVIMA 12MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 4 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Medullary thyroid carcinoma, recurrent endometrial carcinoma, thymic carcinoma, unresectable or metastatic cutaneous melanoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For differentiated thyroid cancer (follicular, papillary, or oncocytic): disease is not amenable to radioactive iodine therapy and unresectable, locally recurrent, persistent, or metastatic. For hepatocellular carcinoma (HCC): disease is unresectable, extrahepatic/metastatic, or liver-confined. For renal cell carcinoma (RCC): the disease is advanced, relapsed, or stage IV. For endometrial carcinoma (EC), the patient meets ALL of the following: 1) The disease is advanced, recurrent, or metastatic, 2) The requested drug will be used in combination with pembrolizumab, 3) The patient experienced disease progression following prior systemic therapy. For anaplastic thyroid carcinoma, the patient meets ALL of the following: 1) The disease is metastatic, 2) The requested drug will be used in combination with pembrolizumab. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | LEUKERAN |
| ***Drug Names*** | LEUKERAN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | LEUPROLIDE |
| ***Drug Names*** | LEUPROLIDE ACETATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Use in combination with growth hormone for children with growth failure and advancing puberty, recurrent androgen receptor positive salivary gland tumors, central precocious puberty |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. |
| ***Age Restrictions*** | CPP: Patient must be less than 12 years old if female and less than 13 years old if male |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | LIDOCAINE PATCHES |
| ***Drug Names*** | LIDOCAINE, LIDOCAN, TRIDACAINE II |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | LIVTENCITY |
| ***Drug Names*** | LIVTENCITY |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 12 years of age or older |
| ***Prescriber Restrictions*** | Prescribed by or in consultation with an infectious disease specialist, transplant specialist, hematologist, or oncologist |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | LONSURF |
| ***Drug Names*** | LONSURF |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Unresectable locally advanced, recurrent, or metastatic esophageal cancer. Unresectable locally advanced or recurrent gastric cancer and gastroesophageal junction cancers. Advanced or metastatic appendiceal adenocarcinoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For colorectal cancer (including appendiceal adenocarcinoma): The disease is advanced or metastatic. For gastric, esophageal, or gastroesophageal junction adenocarcinoma, ALL of the following criteria must be met: 1) The disease is unresectable locally advanced, recurrent, or metastatic, and 2) The patient has been previously treated with at least two prior lines of chemotherapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | LORBRENA |
| ***Drug Names*** | LORBRENA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Anaplastic lymphoma kinase (ALK)-positive recurrent non-small cell lung cancer (NSCLC), proto-oncogene tyrosine-protein kinase ROS1 (ROS1) rearrangement-positive recurrent, advanced, or metastatic NSCLC, symptomatic or relapsed/refractory ALK-positive Erdheim-Chester Disease, inflammatory myofibroblastic tumor (IMT) with ALK translocation (including advanced, recurrent/metastatic, or inoperable uterine sarcoma for IMT with ALK translocation), central nervous system (CNS) brain metastases from ALK rearrangement-positive NSCLC, relapsed or refractory ALK-positive Diffuse Large B-Cell Lymphoma, relapsed or refractory ALK-positive Peripheral T-Cell Lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For recurrent, advanced, or metastatic non-small cell lung cancer: 1) Disease is ALK-positive, OR 2) Disease is positive for ROS1 rearrangement and the requested drug is being used following disease progression on one of the following: crizotinib, entrectinib, ceritinib, or repotrectinib. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | LUMAKRAS |
| ***Drug Names*** | LUMAKRAS |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent KRAS G12C-positive non-small cell lung cancer (NSCLC), recurrent, locally advanced, or metastatic KRAS G12C-positive pancreatic adenocarcinoma, advanced or unresectable KRAS G12C-positive colorectal cancer (including appendiceal adenocarcinoma), progressive KRAS G12C-positive ampullary adenocarcinoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has KRAS G12C mutation-positive disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | LUMIZYME |
| ***Drug Names*** | LUMIZYME |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For Pompe disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | LUPRON PED |
| ***Drug Names*** | LUPRON DEPOT-PED (1-MONTH, LUPRON DEPOT-PED (3-MONTH, LUPRON DEPOT-PED (6-MONTH |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, AND 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, AND 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. |
| ***Age Restrictions*** | CPP: Patient must be less than 12 years old if female and less than 13 years old if male |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | LUPRON-ENDOMETRIOSIS |
| ***Drug Names*** | LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH) |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Breast cancer, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, androgen receptor positive recurrent salivary gland tumor |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For retreatment of endometriosis, the requested drug is used in combination with norethindrone acetate. For uterine fibroids, patient must meet one of the following: 1) diagnosis of anemia (for example, hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) the requested medication will be used prior to surgery for uterine fibroids. For breast cancer, the requested drug is used for hormone receptor (HR)-positive disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | LYNPARZA |
| ***Drug Names*** | LYNPARZA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent HER2-negative, BRCA 1/2-germline mutated breast cancer, recurrent or metastatic HER2-positive, BRCA 1/2-germline mutated breast cancer, uterine leiomyosarcoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For recurrent or metastatic breast cancer: the disease is BRCA 1/2-germline mutated. For prostate cancer: 1) The patient has a BRCA mutation and the requested drug will be used in combination with abiraterone and an oral corticosteroid OR 2) The patient has progressed on prior treatment with an androgen receptor-directed therapy. For ovarian, fallopian tube, or primary peritoneal cancer: The requested drug is used for maintenance therapy for stage II-IV or recurrent disease who are in complete or partial response to chemotherapy. For uterine leiomyosarcoma: 1) the patient has had at least one prior therapy AND 2) the patient has BRCA-altered disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | LYTGOBI |
| ***Drug Names*** | LYTGOBI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Extrahepatic cholangiocarcinoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cholangiocarcinoma: 1) patient has a diagnosis of unresectable, locally advanced or metastatic cholangiocarcinoma, 2) the requested drug is being used as subsequent therapy, AND 3) patient has a disease that has a fibroblast growth factor receptor 2 (FGFR2) gene fusion or other rearrangement. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | MAVYRET |
| ***Drug Names*** | MAVYRET |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh [CTP] class B or C). |
| ***Required Medical Information*** | For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Criteria will be applied consistent with current AASLD-IDSA guidance |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | MEGESTROL |
| ***Drug Names*** | MEGESTROL ACETATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Cancer-related cachexia in adults |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Patient has experienced an inadequate treatment response or intolerance to megestrol 40 milligrams per milliliter (40mg/mL) oral suspension. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | MEKINIST |
| ***Drug Names*** | MEKINIST |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Langerhans cell histiocytosis, Erdheim-Chester disease, Rosai-Dorfman disease, hairy cell leukemia. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For melanoma: 1) The tumor is positive for a BRAF mutation, AND 2) The requested drug will be used as a single agent or in combination with dabrafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. For uveal melanoma: The requested drug will be used as a single agent. For ovarian cancer, fallopian tube cancer, and primary peritoneal cancer: The requested drug will be used to treat persistent or recurrent disease. For papillary, follicular, and oncocytic thyroid carcinoma: 1) The disease is positive for BRAF V600E mutation, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy, AND 3) The requested drug will be used in combination with dabrafenib. For hairy cell leukemia: 1) the requested drug will be used in combination with dabrafenib, AND 2) the patient has not had previous treatment with BRAF inhibitor therapy. For solid tumors: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used in combination with dabrafenib. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | MEKTOVI |
| ***Drug Names*** | MEKTOVI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Adjuvant or neoadjuvant systemic therapy for cutaneous melanoma, Langerhans Cell Histiocytosis, recurrent non-small cell lung cancer (NSCLC) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used in combination with encorafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. For non-small cell lung cancer: 1) The tumor is positive for BRAF V600E mutation, AND 2) The requested drug will be used in combination with encorafenib, AND 3) The disease is advanced, recurrent, or metastatic. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | MEMANTINE |
| ***Drug Names*** | MEMANTINE HYDROCHLORIDE, MEMANTINE HYDROCHLORIDE E |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This prior authorization only applies to patients less than 30 years of age. |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | MEPRON |
| ***Drug Names*** | ATOVAQUONE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Babesiosis, Toxoplasmosis, Pneumocystis jirovecii pneumonia prophylaxis in pediatric patients, mild-to-moderate Pneumocystis jirovecii pneumonia treatment in pediatric patients |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the treatment of mild-to-moderate Pneumocystis jiroveci pneumonia (PCP): the patient had an intolerance or has a contraindication to sulfamethoxazole/trimethoprim (SMX-TMP). For the prevention of PCP and primary toxoplasmosis prophylaxis indications: 1) the patient had an intolerance or has a contraindication to SMX-TMP, AND 2) the patient is immunocompromised. For secondary toxoplasmosis prophylaxis: the patient is immunocompromised. For babesiosis treatment: the requested drug is used concurrently with azithromycin. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Secondary toxoplasmosis prophylaxis: 6 months, All other indications: 3 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | METHYLPHENIDATE |
| ***Drug Names*** | METHYLPHENIDATE HYDROCHLO |
| ***PA Indication Indicator*** | All Medically-accepted Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR 2) The patient has a diagnosis of narcolepsy confirmed by a sleep study OR 3) The requested drug is being prescribed for the treatment of cancer-related fatigue after other causes of fatigue have been ruled out. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | MODAFINIL |
| ***Drug Names*** | MODAFINIL |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Idiopathic hypersomnia |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For excessive sleepiness associated with narcolepsy: The diagnosis has been confirmed by sleep lab evaluation. For excessive sleepiness associated with obstructive sleep apnea (OSA): The diagnosis has been confirmed by polysomnography or home sleep apnea testing (HSAT) with a technically adequate device. For idiopathic hypersomnia, initial request, the diagnosis has been confirmed by ALL of the following: 1) Patient has experienced lapses into sleep or an irrepressible need to sleep during daytime, on a daily basis, for at least 3 months, AND 2) Insufficient sleep syndrome is confirmed absent, AND 3) Cataplexy is absent, AND 4) Fewer than 2 sleep onset rapid eye movement periods (SOREMPs) or no SOREMPs, if the rapid eye movement latency on an overnight sleep study was less than or equal to 15 minutes, AND 5) Average sleep latency of less than or equal to 8 minutes on Multiple Sleep Latency Test or total 24-hour sleep time is greater than or equal to 11 hours, AND 6) Another condition (sleep disorder, medical or psychiatric disorder, or drug/medication use) does not better explain the hypersomnolence and test results. For idiopathic hypersomnia, continuation of therapy: The patient has experienced a decrease in daytime sleepiness from baseline. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | MODEYSO |
| ***Drug Names*** | MODEYSO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 1 year of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | MONJUVI |
| ***Drug Names*** | MONJUVI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | HIV-related B-cell lymphoma, monomorphic post-transplant lymphoproliferative disorder (B-cell type), high-grade B-cell lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For diffuse large B-cell lymphoma (DLBCL) not otherwise specified, HIV-related B-cell lymphoma, monomorphic post-transplant lymphoproliferative disorder (B-cell type), high-grade B-cell lymphoma, diffuse large B-cell lymphoma (DLBCL) not otherwise specified including DLBCL arising from low grade lymphoma: 1) the patient has relapsed or refractory disease, AND 2) the patient is not eligible for autologous stem cell transplant (ASCT). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | MOUNJARO |
| ***Drug Names*** | MOUNJARO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | MRESVIA |
| ***Drug Names*** | MRESVIA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the prevention of lower respiratory tract disease (LRTD) and severe LRTD caused by respiratory syncytial virus (RSV): The patient has not previously received an RSV vaccine (i.e., Abrysvo, Arexvy, Mresvia). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | NAGLAZYME |
| ***Drug Names*** | NAGLAZYME |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Diagnosis of Mucopolysaccharidosis VI (Maroteaux-Lamy syndrome) was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | NERLYNX |
| ***Drug Names*** | NERLYNX |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, brain metastases from HER2-positive breast cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | NEXAVAR |
| ***Drug Names*** | SORAFENIB TOSYLATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Acute myeloid leukemia, soft tissue sarcoma (angiosarcoma, desmoid tumors/aggressive fibromatosis, and solitary fibrous tumor subtypes), gastrointestinal stromal tumor, medullary thyroid carcinoma, osteosarcoma, recurrent chordoma, epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer, lymphoid and/or myeloid neoplasms with eosinophilia and FLT3 rearrangement in chronic or blast phase |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acute myeloid leukemia: the disease is FMS-like tyrosine kinase 3-internal tandem duplication (FLT3-ITD) mutation-positive and any of the following is met :1) the requested drug will be used as maintenance therapy after hematopoietic stem cell transplant, OR 2) the requested drug is being used for low-intensity treatment induction, post-induction therapy, or consolidation therapy, OR 3) the disease is relapsed/refractory. For thyroid carcinoma: histology is follicular, papillary, oncocytic, or medullary. For gastrointestinal stromal tumor (GIST): 1) the disease is residual, unresectable, recurrent, or metastatic/tumor rupture, AND 2) the disease has progressed after use of at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | NINLARO |
| ***Drug Names*** | NINLARO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Relapsed/refractory systemic light chain amyloidosis, Waldenstrom macroglobulinemia, lymphoplasmacytic lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | NITISINONE |
| ***Drug Names*** | NITISINONE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For hereditary tyrosinemia type 1 (HT-1): Diagnosis of HT-1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine), 2) genetic testing (mutation analysis), 3) enzyme assay. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | NORTHERA |
| ***Drug Names*** | DROXIDOPA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For neurogenic orthostatic hypotension (nOH): For initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing or head-up tilt test. For continuation of therapy, patient has experienced a sustained reduction in symptoms of nOH (i.e., decrease in dizziness, lightheadedness, or feeling faint). For both initial and continuation of therapy, the requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) dopamine beta-hydroxylase deficiency, OR 3) non-diabetic autonomic neuropathy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | NOXAFIL SUSP |
| ***Drug Names*** | POSACONAZOLE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug will be used orally. For treatment of oropharyngeal candidiasis: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to fluconazole. |
| ***Age Restrictions*** | 13 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Oropharyngeal candidiasis: 1 month. All other indications: 6 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | NUBEQA |
| ***Drug Names*** | NUBEQA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | NUEDEXTA |
| ***Drug Names*** | NUEDEXTA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pseudobulbar affect (PBA), initial: 1) The patient has a diagnosis of pseudobulbar affect due to underlying neurological disease or injury AND 2) the patient is experiencing PBA episodes characterized by involuntary, sudden, and frequent episodes of laughing and/or crying. For PBA, continuation: The patient has experienced a decrease in pseudobulbar affect (PBA) episodes since starting therapy with the requested drug. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial: 4 months, Continuation: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | NUPLAZID |
| ***Drug Names*** | NUPLAZID |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For hallucinations and delusions associated with Parkinson's disease psychosis, the diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | NURTEC |
| ***Drug Names*** | NURTEC |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acute migraine treatment: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT1 receptor agonist. For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Preventive treatment of migraine, initial: 3 months, All other indications: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | OCTREOTIDE |
| ***Drug Names*** | OCTREOTIDE ACETATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Tumor control of thymomas and thymic carcinomas |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ODOMZO |
| ***Drug Names*** | ODOMZO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | OFEV |
| ***Drug Names*** | OFEV |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For idiopathic pulmonary fibrosis (new starts only): 1) other causes of pulmonary fibrosis have been excluded, AND 2) the patient meets one of the following: a) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR b) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted. For chronic fibrosing interstitial lung diseases with progressive phenotype (progressive pulmonary fibrosis): the patient has confirmed progressive disease (e.g., forced vital capacity [FVC] decline, worsening respiratory symptoms, increased extent of fibrosis on high resolution computed tomography [HRCT]). For treatment of sclerosis-associated interstitial lung disease: the diagnosis was confirmed by a high-resolution computed tomography (HRCT) study of the chest. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | OGIVRI |
| ***Drug Names*** | OGIVRI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | OGSIVEO |
| ***Drug Names*** | OGSIVEO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | OJEMDA |
| ***Drug Names*** | OJEMDA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For relapsed or refractory pediatric low-grade glioma (LGG): the patient's tumor is positive for either a) BRAF fusion or rearrangement OR b) BRAF V600 mutation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | OJJAARA |
| ***Drug Names*** | OJJAARA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Accelerated or blast phase myeloproliferative neoplasms |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For myelofibrosis, patient meets ALL of the following: 1) the patient has a diagnosis of intermediate or high-risk primary myelofibrosis or secondary myelofibrosis (i.e., post-polycythemia vera or post-essential thrombocythemia), AND 2) the patient has anemia defined as hemoglobin less than 10 grams per deciliter (g/dL) or having transfusion-dependent anemia, AND 3) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Jakafi (ruxolitinib) OR has hemoglobin less than 8 g/dL. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | OMEGA-3 |
| ***Drug Names*** | OMEGA-3-ACID ETHYL ESTERS |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For hypertriglyceridemia: Prior to the start of treatment with a triglyceride lowering drug, the patient has/had a pretreatment triglyceride level greater than or equal to 500 milligram per deciliter (mg/dL). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | OMNIPOD |
| ***Drug Names*** | OMNIPOD 5 DEXCOM G7G6 INT, OMNIPOD 5 DEXCOM G7G6 POD, OMNIPOD 5 LIBRE2 PLUS G6, OMNIPOD DASH INTRO KIT (G, OMNIPOD DASH PODS (GEN 4) |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Initial: 1) The patient has diabetes requiring insulin management with multiple daily injections, AND 2) The patient is self-testing glucose levels 4 or more times per day OR the patient is using a continuous glucose monitor, AND 3) The patient has experienced any of the following with the current diabetes regimen: inadequate glycemic control, recurrent hypoglycemia, wide fluctuations in blood glucose, dawn phenomenon with persistent severe early morning hyperglycemia, severe glycemic excursions. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ONTRUZANT |
| ***Drug Names*** | ONTRUZANT |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | ONUREG |
| ***Drug Names*** | ONUREG |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Peripheral T-cell lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | OPIPZA |
| ***Drug Names*** | OPIPZA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For treatment of schizophrenia, 1) the patient meets both of the following: a) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND b) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Lybalvi, Rexulti, Secuado, Vraylar, OR 2) The patient is unable to swallow oral formulations. For adjunctive treatment of major depressive disorder (MDD), 1) the patient meets both of the following: a) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, olanzapine, quetiapine, AND b) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Rexulti, Vraylar, OR 2) The patient is unable to swallow oral formulations. For treatment of irritability associated with autistic disorder: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, risperidone, OR 2) The patient is unable to swallow oral formulations. For the treatment of Tourette's disorder: 1) The patient has had a trial of a generic formulation of aripiprazole or has an intolerance to generic aripiprazole, OR 2) The patient is unable to swallow oral formulations. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | OPSUMIT |
| ***Drug Names*** | OPSUMIT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than 2 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ORGOVYX |
| ***Drug Names*** | ORGOVYX |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ORKAMBI |
| ***Drug Names*** | ORKAMBI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystic fibrosis (CF): the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor). |
| ***Age Restrictions*** | 1 year of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ORSERDU |
| ***Drug Names*** | ORSERDU |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent hormone receptor positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Breast cancer: 1) the disease is estrogen receptor (ER) positive, human epidermal growth factor receptor 2 (HER2)-negative, and ESR1 mutated AND 2) the patient meets either of the following: a) the disease is advanced, recurrent, or metastatic AND the patient has disease progression following at least one line of endocrine therapy OR b) the disease had no response to preoperative systemic therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | OZEMPIC |
| ***Drug Names*** | OZEMPIC |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | PANRETIN |
| ***Drug Names*** | PANRETIN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Topical treatment of cutaneous lesions in patients with non-AIDS-related Kaposi sarcoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | PEGASYS |
| ***Drug Names*** | PEGASYS |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, symptomatic lower-risk myelofibrosis), systemic mastocytosis, adult T-cell leukemia/lymphoma, mycosis fungoides/sezary syndrome, primary cutaneous CD30+ T-cell lymphoproliferative disorders, hairy cell leukemia, Erdheim-Chester disease, initial treatment during pregnancy for chronic myeloid leukemia. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic hepatitis C: Hepatitis C virus (HCV) confirmed by presence of hepatitis C virus HCV RNA in serum prior to starting treatment and the planned treatment regimen. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | HCV: 12-48wks. HBV: 48wks. Other: Plan Yr |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | PEMAZYRE |
| ***Drug Names*** | PEMAZYRE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | PHENYLBUTYRATE |
| ***Drug Names*** | SODIUM PHENYLBUTYRATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic management of urea cycle disorders (UCD): Diagnosis of UCD was confirmed by enzymatic, biochemical, or genetic testing. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | PHESGO |
| ***Drug Names*** | PHESGO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | PIMECROLIMUS |
| ***Drug Names*** | PIMECROLIMUS |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Psoriasis on the face, genitals, or skin folds. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For mild to moderate atopic dermatitis (eczema): the patient meets either of the following criteria: 1) the disease affects sensitive skin areas (e.g., face, genitals, or skin folds), OR 2) the patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one first line therapy agent (e.g., medium or higher potency topical corticosteroid). For all indications: the requested drug is prescribed for short-term or non-continuous chronic use. |
| ***Age Restrictions*** | 2 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | PIQRAY |
| ***Drug Names*** | PIQRAY 200MG DAILY DOSE, PIQRAY 250MG DAILY DOSE, PIQRAY 300MG DAILY DOSE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, phosphatidylinositol-3-kinase catalytic alpha subunit (PIK3CA)-mutated breast cancer in combination with fulvestrant |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | POLYPHARMACY-ACH |
| ***Drug Names*** | AMOXAPINE, DICYCLOMINE HCL, DICYCLOMINE HYDROCHLORIDE, PAROXETINE HCL, PAROXETINE HCL ER, PAROXETINE HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | POMALYST |
| ***Drug Names*** | POMALYST |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Relapsed/refractory systemic light chain amyloidosis, primary central nervous system (CNS) lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For multiple myeloma: patient has previously received at least two prior therapies, including an immunomodulatory agent AND a proteasome inhibitor. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | POSACONAZOLE |
| ***Drug Names*** | POSACONAZOLE DR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug will be used orally. For prophylaxis of invasive Aspergillus and Candida infections: patient weighs greater than 40 kilograms. |
| ***Age Restrictions*** | Treatment of Invasive Aspergillosis: 13 years of age or older, Prophylaxis of Invasive Aspergillus and Candida Infections: 2 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | PREGABALIN |
| ***Drug Names*** | PREGABALIN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Cancer-related neuropathic pain, cancer treatment-related neuropathic pain |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For all indications: If the request is for Lyrica (pregabalin) oral solution, the patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). For the management of postherpetic neuralgia and management of neuropathic pain associated with diabetic peripheral neuropathy: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to generic gabapentin. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | PREVYMIS |
| ***Drug Names*** | PREVYMIS |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For prophylaxis of cytomegalovirus (CMV) infection or disease in hematopoietic stem cell transplant (HSCT): 1) the patient is CMV-seropositive, AND 2) the patient is a recipient of an allogeneic HSCT. For prophylaxis of CMV disease in kidney transplant: 1) the patient is CMV-seronegative, AND 2) the patient is a high risk recipient of kidney transplant. |
| ***Age Restrictions*** | HSCT: 6 months of age or older, kidney transplant: 12 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 7 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | PROCRIT |
| ***Drug Names*** | PROCRIT |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Anemia due to myelodysplastic syndromes (MDS) |
| ***Exclusion Criteria*** | Patients receiving chemotherapy with curative intent. Patients with myeloid cancer. |
| ***Required Medical Information*** | Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval: 1) for all uses except anemia due to chemotherapy or myelodysplastic syndrome (MDS): patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%), AND 2) for all uses except surgery: pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, AND 3) for MDS: pretreatment serum erythropoietin level is 500 international units/L or less. For reauthorizations (patient received erythropoietin treatment in previous month) in all uses except surgery: 1) patient has received at least 12 weeks of erythropoietin therapy, AND 2) patient responded to erythropoietin therapy, AND 3) current Hgb is less than 12 g/dL, AND 4) for all uses except anemia due to chemotherapy or MDS: patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Anemia with CKD, zidovudine: Plan Year, All others: 16 weeks |
| ***Other Criteria*** | Coverage includes use in anemia in patients who will not/cannot receive blood transfusions (e.g., religious beliefs). Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | PULMOZYME |
| ***Drug Names*** | PULMOZYME |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | PYZCHIVA |
| ***Drug Names*** | PYZCHIVA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | QINLOCK |
| ***Drug Names*** | QINLOCK |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Gastrointestinal stromal tumor (GIST) for residual, unresectable, tumor rupture, recurrent, or progressive disease. Metastatic or unresectable cutaneous melanoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For residual, unresectable, tumor rupture, advanced, recurrent/metastatic, or progressive gastrointestinal stromal tumor (GIST): 1) Patient has received prior treatment with 3 or more kinase inhibitors, including imatinib OR 2) Patient has experienced disease progression following treatment with avapritinib and dasatinib OR 3) Patient has received prior treatment with imatinib and is intolerant of second-line sunitinib. For cutaneous melanoma: 1) Disease is metastatic or unresectable AND 2) Disease is positive for KIT activating mutations AND 3) Requested drug will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | QUETIAPINE XR |
| ***Drug Names*** | QUETIAPINE FUMARATE ER |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Maintenance monotherapy treatment in bipolar I disorder, monotherapy treatment of generalized anxiety disorder, monotherapy treatment of major depressive disorder |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For all indications: If the patient is 65 years of age or older AND is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, sertraline, clonazepam, escitalopram, alprazolam, zolpidem) with the requested drug, the prescriber determined that taking multiple central nervous system (CNS) active medications is medically necessary. [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls]. For treatment of schizophrenia: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine immediate-release, risperidone, ziprasidone. For acute treatment of manic or mixed episodes associated with bipolar I disorder or maintenance treatment of bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine immediate-release, risperidone, ziprasidone. For acute treatment of depressive episodes associated with bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: lurasidone, olanzapine, quetiapine immediate-release. For acute treatment of depressive episodes associated with bipolar II disorder: The patient experienced an inadequate treatment response or intolerance to generic quetiapine immediate-release. For adjunctive treatment of major depressive disorder (MDD): The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, olanzapine, quetiapine immediate-release. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | QUININE SULFATE |
| ***Drug Names*** | QUININE SULFATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Babesiosis, uncomplicated Plasmodium vivax malaria. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For babesiosis: the requested drug is used in combination with clindamycin. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 1 month |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | QULIPTA |
| ***Drug Names*** | QULIPTA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial: 3 months, Continuation: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | RALDESY |
| ***Drug Names*** | RALDESY |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The patient is unable to swallow trazodone tablets. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | RELISTOR INJ |
| ***Drug Names*** | RELISTOR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the treatment of opioid-induced constipation in a patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation: 1) the patient is unable to tolerate oral medications, OR 2) the patient meets one of the following criteria: A) experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in a patient with chronic non-cancer pain (e.g., Movantik), OR B) the patient has a contraindication that would prohibit a trial of an oral drug indicated for opioid-induced constipation in a patient with chronic non-cancer pain (e.g., Movantik). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | REMICADE |
| ***Drug Names*** | INFLIXIMAB, REMICADE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Behcet's disease, hidradenitis suppurativa, sarcoidosis, Takayasu's arteritis, uveitis. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) meets any of the following: a) requested drug will be used in combination with methotrexate (MTX), b) pt has experienced an intolerance or contraindication to MTX, AND 2) pt meets any of the following: a) pt has experienced an inadequate treatment response, intolerance or contraindication to MTX, b) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR the pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | For hidradenitis suppurativa (new starts only): Pt has severe, refractory disease. For uveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to immunosuppressive therapy for uveitis OR 2) pt has a contraindication that would prohibit a trial of immunosuppressive therapy for uveitis. For all indications: The patient experienced an intolerable adverse event to Renflexis and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | RENFLEXIS |
| ***Drug Names*** | RENFLEXIS |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Behcet's disease, hidradenitis suppurativa, sarcoidosis, Takayasu's arteritis, uveitis |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) meets any of the following: a) requested drug will be used in combination with methotrexate (MTX), b) pt has experienced an intolerance or has a contraindication to MTX, AND 2) pt meets any of the following: a) pt has experienced an inadequate treatment response, intolerance or has a contraindication to MTX, b) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | For hidradenitis suppurativa (new starts only): pt has severe, refractory disease. For uveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to immunosuppressive therapy for uveitis OR 2) pt has a contraindication that would prohibit a trial of immunosuppressive therapy for uveitis. |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | REPATHA |
| ***Drug Names*** | REPATHA, REPATHA SURECLICK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | RETEVMO |
| ***Drug Names*** | RETEVMO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent rearranged during transfection (RET)-rearrangement positive non-small cell lung cancer (NSCLC), brain metastases from RET fusion-positive NSCLC, Langerhans cell histiocytosis with a RET gene fusion, symptomatic or relapsed/refractory Erdheim-Chester Disease with a RET gene fusion, symptomatic or relapsed/refractory Rosai-Dorfman Disease with a RET gene fusion, occult primary cancer with RET gene fusion, solid tumors with RET-gene fusion for recurrent disease |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC), patient must meet all of the following: 1) The disease is recurrent, advanced or metastatic, AND 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement positive. For solid tumors, patient must meet all of the following: 1) The disease is recurrent, persistent, progressive, unresectable, locally advanced, or metastatic, 2) The patient has progressed on or following prior systemic treatment or has no satisfactory alternative treatment options, AND 3) The tumor is RET fusion-positive. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | REVCOVI |
| ***Drug Names*** | REVCOVI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | REVLIMID |
| ***Drug Names*** | LENALIDOMIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome, myeloproliferative neoplasms, Kaposi Sarcoma, Langerhans cell histiocytosis, Rosai-Dorfman disease, peripheral T-Cell lymphomas not otherwise specified, angioimmunoblastic T-cell lymphoma (AITL), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, adult T-cell leukemia/lymphoma, hepatosplenic T-cell lymphoma, primary central nervous system (CNS) lymphoma, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), human immunodeficiency virus (HIV)-related B-cell lymphomas, monomorphic post-transplant lymphoproliferative disorder, diffuse large B-cell lymphoma, multicentric Castlemans disease, high-grade B-cell lymphomas, histologic transformation of indolent lymphoma to diffuse large B-cell lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For myelodysplastic syndrome (MDS): patient has lower risk MDS with symptomatic anemia per the Revised International Prognostic Scoring System (IPSS-R), International Prognostic Scoring System (IPSS), or World Health organization (WHO) classification-based Prognostic Scoring System (WPSS). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | REVUFORJ |
| ***Drug Names*** | REVUFORJ |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | REZDIFFRA |
| ***Drug Names*** | REZDIFFRA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For noncirrhotic nonalcoholic steatohepatitis (NASH), initial: patient has moderate to advanced liver fibrosis (consistent with Stages F2 to F3 ) at baseline, which was confirmed by liver biopsy or magnetic resonance elastography (MRE). For NASH (continuation): The patient demonstrates a beneficial response to therapy (for example, improvement in liver function such as reduction in alanine aminotransferase (ALT), reduction of liver fat content by imaging such as magnetic resonance imaging-protein density fat fraction (MRI-PDFF) or FibroScan controlled attenuation parameter (CAP)). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | The requested drug is being prescribed by, or in consultation with, a gastroenterologist or hepatologist. |
| ***Coverage Duration*** | Initial: Plan Year, Continuation: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | REZLIDHIA |
| ***Drug Names*** | REZLIDHIA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | REZUROCK |
| ***Drug Names*** | REZUROCK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 12 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | RINVOQ |
| ***Drug Names*** | RINVOQ, RINVOQ LQ |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active rheumatoid arthritis, active psoriatic arthritis, active polyarticular juvenile idiopathic arthritis, and active ankylosing spondylitis (new starts only): Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (for example, adalimumab, etanercept). For moderately to severely active ulcerative colitis and moderately to severely active Crohn's disease: Patient meets one of the following: 1) Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (for example, adalimumab), OR 2) If a TNF inhibitor is clinically inadvisable, the patient has tried at least one systemic therapy. For atopic dermatitis (new starts only): 1) Patient has refractory, moderate to severe disease, AND 2) At least 10% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, AND 3) Patient has had an inadequate response to treatment with at least one other systemic drug product, including biologics, or use of these therapies are inadvisable. For atopic dermatitis (continuation of therapy): Patient achieved or maintained positive clinical response. For non-radiographic axial spondyloarthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor. |
| ***Age Restrictions*** | Atopic dermatitis: 12 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Atopic dermatitis (initial): 6 months, Atopic dermatitis (continuation), All others: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | ROMVIMZA |
| ***Drug Names*** | ROMVIMZA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ROZLYTREK |
| ***Drug Names*** | ROZLYTREK |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent ROS1-positive non-small cell lung cancer (NSCLC), Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, ROS1-gene fusion-positive cutaneous melanoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors: the disease is without a known acquired resistance mutation. For ROS1-positive non-small cell lung cancer: the patient has recurrent, advanced, or metastatic disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | RUBRACA |
| ***Drug Names*** | RUBRACA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Uterine leiomyosarcoma, pancreatic adenocarcinoma, advanced (stage II-IV) epithelial ovarian, fallopian tube, or primary peritoneal cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For metastatic castration-resistant prostate cancer with a deleterious breast cancer susceptibility gene (BRCA) mutation (germline and/or somatic): 1) patient has been treated with androgen receptor-directed therapy, AND 2) patient has been treated with a taxane-based chemotherapy or the patient is not fit for chemotherapy, AND 3) the requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. For maintenance treatment of BRCA mutated ovarian, fallopian tube, primary peritoneal cancer: 1) the patient has advanced (stage II-IV) disease and is in complete or partial response to primary therapy, OR 2) the patient has recurrent disease and is in complete or partial response to platinum-based chemotherapy. For uterine leiomyosarcoma: 1) the requested drug is used as second-line or subsequent therapy, AND 2) the patient has BRCA-altered disease. For pancreatic adenocarcinoma: 1) the patient has metastatic disease, AND 2) the patient has somatic or germline BRCA or PALB-2 mutations. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | RYBELSUS |
| ***Drug Names*** | RYBELSUS |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | RYDAPT |
| ***Drug Names*** | RYDAPT |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Re-induction in residual disease for AML, maintenance therapy for AML, myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or FLT3 rearrangements |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acute myeloid leukemia (AML): AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and Fibroblast growth factor receptor type 1 (FGFR1) or FLT3 rearrangements: the disease is in chronic or blast phase. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | SANTYL |
| ***Drug Names*** | SANTYL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For debriding chronic dermal ulcers and severely burned areas, continuation: 1) wound has been evaluated since beginning treatment with the requested drug AND 2) granulation tissue is not well established. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | SAPROPTERIN |
| ***Drug Names*** | JAVYGTOR, SAPROPTERIN DIHYDROCHLORI, ZELVYSIA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For phenylketonuria (PKU): For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment (including before dietary management) phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced improvement (e.g., reduction in blood phenylalanine levels, improvement in neuropsychiatric symptoms). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial: 2 months, All others: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | SCEMBLIX |
| ***Drug Names*** | SCEMBLIX |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in chronic phase or blast phase |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic myeloid leukemia (CML) in chronic phase: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) Patient meets one of the following: A) Patient has newly diagnosed CML and has resistance or intolerance to imatinib, dasatinib, or nilotinib OR B) Patient has previously treated CML AND at least one of the prior treatments was imatinib, dasatinib, or nilotinib OR C) Patient is positive for the T315I mutation, AND 3) Patient is negative for the following mutations: A337T, P465S, and F359V/I/C. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | SIGNIFOR |
| ***Drug Names*** | SIGNIFOR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | Prescribed by or in consultation with an endocrinologist |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | SILDENAFIL |
| ***Drug Names*** | SILDENAFIL CITRATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) If the request is for an adult, pretreatment pulmonary vascular resistance is greater than 2 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | SIRTURO |
| ***Drug Names*** | SIRTURO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | Prescribed by or in consultation with an infectious disease specialist |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | SKYRIZI |
| ***Drug Names*** | SKYRIZI, SKYRIZI PEN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | SOMATULINE DEPOT |
| ***Drug Names*** | LANREOTIDE ACETATE, SOMATULINE DEPOT |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Tumor control of neuroendocrine tumors (NETs) (including tumors of the lung, thymus, unresected primary gastrinoma, well-differentiated grade 3 NETs not of gastroenteropancreatic origin with favorable biology, and pheochromocytoma/paraganglioma) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | SOMAVERT |
| ***Drug Names*** | SOMAVERT |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | SOTYKTU |
| ***Drug Names*** | SOTYKTU |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | SPRYCEL |
| ***Drug Names*** | DASATINIB |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Gastrointestinal stromal tumor (GIST), metastatic and/or widespread chondrosarcoma, recurrent chordoma, T-cell acute lymphoblastic leukemia (ALL), and Philadelphia (Ph)-like B-ALL, myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase, cutaneous melanoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia (Ph) chromosome or BCR-ABL gene AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L. For acute lymphoblastic leukemia (ALL), the patient has a diagnosis of one of the following: 1) Philadelphia chromosome positive ALL, including patients who have received a hematopoietic stem cell transplant: Diagnosis that has been confirmed by detection of the Ph chromosome or BCR-ABL gene AND if patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L OR 2) Ph-like B-ALL with ABL-class kinase fusion OR 3) Relapsed or refractory T-cell ALL with ABL-class translocation. For gastrointestinal stromal tumor (GIST): 1) Patient meets all of the following: A) Disease is residual, unresectable, recurrent/progressive, or metastatic/tumor rupture, B) Patient has received prior therapy with avapritinib AND C) Patient is positive for platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutations. For cutaneous melanoma: 1) Disease is metastatic or unresectable, 2) Disease is positive for c-KIT activating mutations AND 3) Requested drug will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | STELARA |
| ***Drug Names*** | STELARA, USTEKINUMAB |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | STIVARGA |
| ***Drug Names*** | STIVARGA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Osteosarcoma, angiosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma, rhabdomyosarcoma, soft tissue sarcomas of the extremities, body wall, head and neck, appendiceal adenocarcinoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For colorectal cancer: 1) The disease is advanced or metastatic, AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Lonsurf (trifluridine/tipiracil). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | SUTENT |
| ***Drug Names*** | SUNITINIB MALATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Thyroid carcinoma (follicular, medullary, papillary, and oncocytic), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, alveolar soft part sarcoma, and extraskeletal myxoid chondrosarcoma subtypes), recurrent chordoma, thymic carcinoma, lymphoid and/or myeloid neoplasms with eosinophilia and FLT3 rearrangement in chronic or blast phase, pheochromocytoma, paraganglioma, well differentiated grade 3 neuroendocrine tumors |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For renal cell carcinoma (RCC): 1) The disease is relapsed, advanced, or stage IV OR 2) the requested drug is being used as adjuvant treatment for patients that are at high risk of recurrent RCC following nephrectomy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | SYMDEKO |
| ***Drug Names*** | SYMDEKO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystic fibrosis: the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor). |
| ***Age Restrictions*** | 6 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | SYMPAZAN |
| ***Drug Names*** | SYMPAZAN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Seizures associated with Dravet syndrome |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | Seizures associated with Lennox-Gastaut syndrome (LGS): 2 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | SYNAREL |
| ***Drug Names*** | SYNAREL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, AND 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, AND 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. |
| ***Age Restrictions*** | CPP: Patient must be less than 12 years of age if female and less than 13 years of age if male, Endometriosis: 18 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | CPP: Plan Year, Endometriosis: max 6 months total |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TABLOID |
| ***Drug Names*** | TABLOID |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Acute lymphocytic leukemia (ALL), circumscribed glioma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | TABRECTA |
| ***Drug Names*** | TABRECTA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent non-small cell lung cancer (NSCLC), NSCLC with high-level mesenchymal-epithelial transition (MET) amplification, central nervous system (CNS) brain metastases from MET exon-14 mutated NSCLC |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For recurrent, advanced, or metastatic non-small cell lung cancer (NSCLC): Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TADALAFIL (BPH) |
| ***Drug Names*** | TADALAFIL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Erectile Dysfunction. |
| ***Required Medical Information*** | For benign prostatic hyperplasia (BPH): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to both of the following: 1) alpha blocker, 2) 5-alpha reductase inhibitor (5-ARI). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | TADALAFIL (PAH) |
| ***Drug Names*** | ALYQ, TADALAFIL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than 2 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TAFINLAR |
| ***Drug Names*** | TAFINLAR |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Langerhans cell histiocytosis, Erdheim-Chester disease, hairy cell leukemia. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For melanoma: 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with trametinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. For non-small cell lung cancer: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used as a single agent or in combination with trametinib. For papillary, follicular, and oncocytic thyroid carcinoma: 1) The tumor is BRAF V600E-positive, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy, AND 3) the requested drug will be used in combination with trametinib. For Langerhans Cell Histiocytosis and Erdheim-Chester Disease: The disease is positive for a BRAF V600E mutation. For hairy cell leukemia: 1) the requested drug will be used in combination with trametinib, AND 2) the patient has not had previous treatment with BRAF inhibitor therapy. For solid tumors: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used in combination with trametinib. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TAGRISSO |
| ***Drug Names*** | TAGRISSO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC), brain metastases from sensitizing EGFR mutation-positive NSCLC, leptomeningeal metastases from EGFR mutation-positive NSCLC |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC), the requested drug is used in any of the following settings: 1) The patient meets both of the following: a) patient has unresectable, metastatic, advanced, or recurrent NSCLC (including brain and/or leptomeningeal metastases from NSCLC) and b) patient has a sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease, OR 2) The patient meets both of the following: a) request is for adjuvant treatment of NSCLC following tumor resection and b) patient has EGFR mutation-positive disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TALZENNA |
| ***Drug Names*** | TALZENNA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent germline breast cancer susceptibility gene (BRCA)-mutated breast cancer |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TARGRETIN TOPICAL |
| ***Drug Names*** | BEXAROTENE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Mycosis fungoides (MF)/Sezary syndrome (SS), smoldering adult T-cell leukemia/lymphoma (ATLL), primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TASIGNA |
| ***Drug Names*** | NILOTINIB HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase, pigmented villonodular synovitis/tenosynovial giant cell tumor, cutaneous melanoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I, Y253H, E255K/V, and F359V/C/I mutations. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If the patient has experienced resistance to an alternative tyrosine kinase inhibitor for ALL, patient is negative for T315I, Y253H, E255K/V, F359V/C/I and G250E mutations. For gastrointestinal stromal tumor (GIST): 1) Disease is residual, unresectable, recurrent/progressive, or metastatic/tumor rupture, AND 2) Disease has progressed on at least 2 Food and Drug Administration (FDA)-approved therapies (e.g. imatinib, sunitinib, regorafenib, ripretinib). For cutaneous melanoma: 1) Disease is metastatic or unresectable, AND 2) Disease is positive for c-KIT activating mutations, AND 3) Requested drug will be used as subsequent therapy, AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | TAVNEOS |
| ***Drug Names*** | TAVNEOS |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For continuation of treatment for severe anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis: the patient has experienced benefit from therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TAZAROTENE |
| ***Drug Names*** | TAZAROTENE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For plaque psoriasis, the patient meets the following criteria: 1) the patient has less than or equal to 20 percent of affected body surface area (BSA), AND 2) the patient experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR has a contraindication that would prohibit a trial of topical corticosteroids. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | TAZVERIK |
| ***Drug Names*** | TAZVERIK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | Epithelioid sarcoma: 16 years of age or older, Follicular lymphoma: 18 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TECENTRIQ |
| ***Drug Names*** | TECENTRIQ |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Single agent maintenance for extensive small cell lung cancer following combination treatment with etoposide and carboplatin, subsequent therapy for peritoneal mesothelioma, pericardial mesothelioma, and tunica vaginalis testis mesothelioma, urothelial carcinoma, stage IIIB non-small cell lung cancer (NSCLC), cervical cancer (persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix (NECC), squamous cell carcinoma, adenocarcinoma, adenosquamous cell carcinoma of the cervix). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): 1) the patient has recurrent, advanced, or metastatic disease OR 2) the patient has stage II to IIIB disease AND the requested drug will be used as adjuvant treatment following resection and adjuvant chemotherapy. For hepatocellular carcinoma, the requested drug will be used as initial treatment in combination with bevacizumab. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TECENTRIQ HYBREZA |
| ***Drug Names*** | TECENTRIQ HYBREZA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Cervical cancer (persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix (NECC), squamous cell carcinoma, adenocarcinoma, adenosquamous cell carcinoma of the cervix), stage IIIB non-small cell lung cancer (NSCLC), subsequent therapy for peritoneal mesothelioma, pericardial mesothelioma, and tunica vaginalis testis mesothelioma, single agent maintenance for extensive small cell lung cancer following combination treatment with etoposide and carboplatin, bladder cancer, urothelial carcinoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): 1) the patient has recurrent, advanced or metastatic disease OR 2) the patient has stage II to IIIB disease AND the requested drug will be used as adjuvant treatment following resection and adjuvant chemotherapy. For hepatocellular carcinoma, the requested drug will be used as initial treatment in combination with bevacizumab. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TEMAZEPAM |
| ***Drug Names*** | TEMAZEPAM |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For short-term treatment of insomnia: 1) The prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to doxepin (3 mg or 6 mg) or ramelteon, AND 3) If the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.].. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization only applies to patients 65 years of age or older. |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | TEPMETKO |
| ***Drug Names*** | TEPMETKO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent non-small cell lung cancer (NSCLC), NSCLC with high level mesenchymal-epithelial transition (MET) amplification, central nervous system (CNS) cancer including brain metastases and leptomeningeal metastases from MET exon-14 mutated NSCLC |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For recurrent, advanced, or metastatic non-small cell lung cancer (NSCLC): Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TERBINAFINE TABS |
| ***Drug Names*** | TERBINAFINE HCL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the treatment of onychomycosis due to dermatophytes (tinea unguium), patient meets ALL of the following: 1) the patient will use the requested drug orally., AND 2) the requested drug is being prescribed for non-continuous use. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 12 weeks |
| ***Other Criteria*** | Prior authorization applies to greater than cumulative 90 days of therapy per year. |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TERIPARATIDE |
| ***Drug Names*** | BONSITY, TERIPARATIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For postmenopausal osteoporosis: patient has ONE of the following: 1) history of fragility fracture, OR 2) pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has ONE of the following: 1) history of osteoporotic vertebral or hip fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability AND patient has ANY of the following: a) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR b) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For glucocorticoid-induced osteoporosis: patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND patient meets ANY of the following: 1) patient has a history of fragility fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial: 24 months, Continuation: Plan Year |
| ***Other Criteria*** | Continuation of therapy: If the patient has received greater than or equal to 24 months of therapy with any parathyroid hormone analog: 1) The patient remains at or has returned to having a high risk for fracture, AND 2) The benefit of therapy with this prescribed medication outweighs the potential risks for this patient. Patient has high FRAX fracture probability if the 10-year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture. |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | TESTOSTERONE CYPIONATE INJ |
| ***Drug Names*** | DEPO-TESTOSTERONE, TESTOSTERONE CYPIONATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Gender Dysphoria |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TESTOSTERONE ENANTHATE INJ |
| ***Drug Names*** | TESTOSTERONE ENANTHATE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Gender Dysphoria |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TETRABENAZINE |
| ***Drug Names*** | TETRABENAZINE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Tic disorders, tardive dyskinesia |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For treatment of chorea associated with Huntington's disease, initial: patient must meet both of the following:1) patient demonstrates characteristic motor examination features, AND 2) patient has experienced an inadequate treatment response or intolerable adverse event to deutetrabenazine. For tardive dyskinesia, initial: patient must meet all of the following: 1) patient exhibits clinical manifestation of the disease, AND 2) patient's disease has been assessed through clinical examination or with a structured evaluative tool (e.g., Abnormal Involuntary Movement Scale [AIMS], Dyskinesia Identification System: Condensed User Scale [DISCUS]), AND 3) patient has experienced an inadequate treatment response or intolerable adverse event to deutetrabenazine. For treatment of tardive dyskinesia and treatment of chorea associated with Huntington's disease, continuation: patient demonstrates a beneficial response to therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial: 6 months, Continuation: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | THALOMID |
| ***Drug Names*** | THALOMID |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Acquired immunodeficiency syndrome (AIDS)-related aphthous stomatitis, Kaposi sarcoma, multicentric Castleman's disease, Rosai-Dorfman disease, Langerhans cell histiocytosis, pediatric medulloblastoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TIBSOVO |
| ***Drug Names*** | TIBSOVO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Conventional (grades 1-3) or dedifferentiated chondrosarcoma, central nervous system (CNS) cancers (astrocytoma, oligodendroglioma) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Patient has disease with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. For acute myeloid leukemia (AML): 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient declines or has comorbidities that preclude use of intensive induction chemotherapy, OR 2) the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML, OR 4) therapy will be used for consolidation therapy. For locally advanced, unresectable, resected gross residual, or metastatic cholangiocarcinoma: the requested drug will be used as subsequent treatment for progression on or after systemic treatment. For CNS cancers: 1) disease is recurrent, residual, or progressive, AND 2) patient has oligodendroglioma or astrocytoma. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TOBI INHALER |
| ***Drug Names*** | TOBI PODHALER |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-cystic fibrosis bronchiectasis |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystic fibrosis and non-cystic fibrosis bronchiectasis: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of Pseudomonas aeruginosa infection or colonization in the airways. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TOBRAMYCIN |
| ***Drug Names*** | TOBRAMYCIN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-cystic fibrosis bronchiectasis |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystic fibrosis and non-cystic fibrosis bronchiectasis: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of Pseudomonas aeruginosa infection or colonization in the airways. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TOPICAL LIDOCAINE |
| ***Drug Names*** | GLYDO, LIDOCAINE, LIDOCAINE HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being used for topical anesthesia, AND 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are Food and Drug Administration (FDA) approved for topical use. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 months |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TOPICAL TACROLIMUS |
| ***Drug Names*** | TACROLIMUS |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Psoriasis on the face, genitals, or skin folds. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderate to severe atopic dermatitis (eczema): the patient meets either of the following criteria: 1) the disease affects sensitive skin areas (e.g., face, genitals, or skin folds), OR 2) the patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one first line therapy agent (e.g., medium or higher potency topical corticosteroid). For all indications: the requested drug is being prescribed for short-term or non-continuous chronic use. |
| ***Age Restrictions*** | Tacrolimus 0.03% 2 years of age or older, Tacrolimus 0.1% 16 years of age or older. |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | TOPICAL TESTOSTERONES |
| ***Drug Names*** | TESTOSTERONE, TESTOSTERONE PUMP |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Gender Dysphoria |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TOPICAL TRETINOIN |
| ***Drug Names*** | TRETINOIN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TOREMIFENE |
| ***Drug Names*** | TOREMIFENE CITRATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Congenital/acquired QT prolongation (long QT syndrome), uncorrected hypokalemia, or uncorrected hypomagnesemia. |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TRAZIMERA |
| ***Drug Names*** | TRAZIMERA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib AND 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TREMFYA |
| ***Drug Names*** | TREMFYA, TREMFYA INDUCTION PACK FO, TREMFYA PEN |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | TREPROSTINIL INJ |
| ***Drug Names*** | TREPROSTINIL |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 2 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TRIENTINE |
| ***Drug Names*** | TRIENTINE HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | TRIKAFTA |
| ***Drug Names*** | TRIKAFTA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For cystic fibrosis: the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor). |
| ***Age Restrictions*** | 2 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TRINTELLIX |
| ***Drug Names*** | TRINTELLIX |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to ONE of the following generic products: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | TRULICITY |
| ***Drug Names*** | TRULICITY |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | For glycemic control in type 2 diabetes mellitus: 10 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TRUQAP |
| ***Drug Names*** | TRUQAP |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For breast cancer: 1) the disease is recurrent, locally advanced, or metastatic, 2) the disease is hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative, 3) the requested drug will be used in combination with fulvestrant, 4) the disease possesses one or more PIK3CA/AKT/PTEN-alterations AND the patient meets either of the following, a) the patient has progressed on at least one endocrine therapy based regimen, b) the patient experienced recurrence on or within 12 months of completing adjuvant therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | TRUXIMA |
| ***Drug Names*** | TRUXIMA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, extranodal marginal zone lymphoma (EMZL) of the stomach, EMZL of nongastric sites (noncutaneous)), Burkitt lymphoma, high-grade B-cell lymphoma, histological transformation of indolent lymphomas to diffuse large B-cell lymphoma, histological transformation of chronic lymphocytic leukemia (CLL)/SLL to diffuse large B-cell lymphoma, primary cutaneous B-cell lymphoma, Castleman disease, human immunodeficiency virus (HIV)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), B-cell lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, nodular lymphocyte-predominant Hodgkin lymphoma, primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, relapsing remitting multiple sclerosis, immune checkpoint inhibitor-related toxicities, Rosai-Dorfman disease, pediatric aggressive mature B-cell lymphomas (including Burkitt-like lymphoma, primary mediastinal large B-cell lymphoma), and pediatric mature B-cell acute leukemia, neuromyelitis optica spectrum disorder |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate treatment response, intolerance, or contraindication to MTX OR b) inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | TUKYSA |
| ***Drug Names*** | TUKYSA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, HER2-positive biliary tract cancer (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For colorectal cancer (including appendiceal adenocarcinoma): 1) the patient has advanced, unresectable, or metastatic disease, AND 2) the patient has human epidermal growth factor receptor 2 (HER2)-positive disease, AND 3) the patient has RAS wild-type disease, AND 4) the requested drug will be used in combination with trastuzumab, AND 5) the patient has not previously been treated with a HER2 inhibitor. For biliary tract cancer: 1) the patient has unresectable or metastatic disease, AND 2) the patient has human epidermal growth factor receptor 2 (HER2)-positive disease, AND 3) the requested drug will be used in combination with trastuzumab. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TURALIO |
| ***Drug Names*** | TURALIO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Langerhans cell histiocytosis, Erdheim-Chester disease, Rosai-Dorfman disease |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For Langerhans cell histiocytosis: 1) disease has colony stimulating factor 1 receptor (CSF1R) mutation. For Erdheim-Chester disease and Rosai-Dorfman disease: 1) disease has CSF1R mutation, AND 2) patient has any of the following: a) symptomatic disease OR b) relapsed/refractory disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | TYENNE |
| ***Drug Names*** | TYENNE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Castleman's disease, systemic sclerosis-associated interstitial lung disease |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active rheumatoid arthritis (new starts only): 1) Patient has experienced an inadequate treatment response, intolerance or contraindication to methotrexate (MTX) OR 2) Patient has experienced an inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For treatment of sclerosis-associated interstitial lung disease: the diagnosis was confirmed by a high-resolution computed tomography (HRCT) study of the chest. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | UBRELVY |
| ***Drug Names*** | UBRELVY |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acute treatment of migraine: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT1 receptor agonist. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | UCERIS |
| ***Drug Names*** | BUDESONIDE ER |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the induction of remission of active, mild to moderate ulcerative colitis: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one 5-aminosalicylic acid (5-ASA) therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 2 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | UPTRAVI |
| ***Drug Names*** | UPTRAVI, UPTRAVI TITRATION PACK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 2 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | VALCHLOR |
| ***Drug Names*** | VALCHLOR |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Smoldering adult T-cell leukemia/lymphoma (ATLL), Stage 2 or higher mycosis fungoides (MF)/Sezary syndrome (SS), primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, CD30-positive lymphomatoid papulosis (LyP), unifocal Langerhans cell histiocytosis (LCH) with isolated skin disease |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | VANFLYTA |
| ***Drug Names*** | VANFLYTA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Re-induction in patients with residual disease for AML |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acute myeloid leukemia (AML): 1) AML is FMS-like tyrosine kinase 3 (FLT3) internal tandem duplication (ITD)-positive and 2) medication will be used for induction, re-induction, consolidation, or maintenance therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | VELCADE |
| ***Drug Names*** | BORTEZOMIB |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, acute lymphoblastic leukemia, Kaposi's sarcoma, pediatric Classic Hodgkin lymphoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | VELSIPITY |
| ***Drug Names*** | VELSIPITY |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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| ***Prior Authorization Group*** | VENCLEXTA |
| ***Drug Names*** | VENCLEXTA, VENCLEXTA STARTING PACK |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Mantle cell lymphoma, blastic plasmacytoid dendritic cell neoplasm (BPDCN), multiple myeloma, relapsed or refractory acute myeloid leukemia (AML), poor-risk AML, therapy related AML, post-induction therapy for AML following response to previous lower intensity therapy with the same regimen, Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, relapsed or refractory systemic light chain amyloidosis with translocation t(11:14), accelerated or blast phase myeloproliferative neoplasms, B-cell acute lymphoblastic leukemia/T-cell acute lymphoblastic leukemia (B-ALL/T-ALL), hairy cell leukemia, higher risk myelodysplastic syndromes, chronic myelomonocytic leukemia (CMML)-2. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For acute myeloid leukemia (AML): 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient has comorbidities that preclude use of intensive induction chemotherapy, OR 2) will be used for induction or consolidation therapy in patients with poor-risk or therapy related AML, OR 3) patient has relapsed or refractory AML, OR 4) will be used for post-induction therapy for AML following response to previous lower intensity therapy with the same regimen. For blastic plasmacytoid dendritic cell neoplasm (BPDCN): 1) patient has systemic disease being treated with palliative intent, OR 2) patient has relapsed or refractory disease. For multiple myeloma: 1) the disease is relapsed or progressive, AND 2) the requested drug will be used in combination with one of the following: a) dexamethasone, b) dexamethasone and daratumumab c) dexamethasone with bortezomib, carfilzomib, or ixazomib AND 3) patient has t(11:14) translocation. For Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma: 1) patient has previously treated disease that did not respond to primary therapy, OR 2) patient has progressive or relapsed disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | VERQUVO |
| ***Drug Names*** | VERQUVO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For symptomatic chronic heart failure: the patient has a left ventricular ejection fraction (LVEF) less than 45 percent AND 2) the patient is receiving therapy for heart failure (for example, angiotensin converting enzyme inhibitor [ACEI], angiotensin II receptor blocker [ARB], angiotensin receptor-neprilysin inhibitor [ARNI], beta-blocker, mineralocorticoid receptor antagonist [MRA], sodium-glucose co-transporter 2 [SGLT2] inhibitor). For initial therapy, the patient meets ANY of the following: 1) hospitalization for heart failure within the past 6 months OR 2) use of outpatient intravenous diuretics for heart failure within the past 3 months. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | VERSACLOZ |
| ***Drug Names*** | VERSACLOZ |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the treatment of a severely ill patient with schizophrenia who failed to respond adequately to standard antipsychotic treatment (i.e., treatment-resistant schizophrenia): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Lybalvi, Rexulti, Secuado, Vraylar. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | VERZENIO |
| ***Drug Names*** | VERZENIO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent breast cancer, endometrial cancer, in combination with letrozole for estrogen receptor positive tumor |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For breast cancer: 1) the disease is either: a) advanced, recurrent, or metastatic, OR b) early breast cancer AND 2) the patient has hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative disease, AND 3) the requested drug will be used in combination with endocrine therapy or as a single agent. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | VIGABATRIN |
| ***Drug Names*** | VIGABATRIN, VIGADRONE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For complex partial seizures (i.e., focal impaired awareness seizures): patient has experienced an inadequate treatment response to at least two antiepileptic drugs for complex partial seizures (i.e., focal impaired awareness seizures). |
| ***Age Restrictions*** | Infantile Spasms: 1 month to 2 years of age. Complex partial seizures (i.e., focal impaired awareness seizures): 2 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | VIGAFYDE |
| ***Drug Names*** | VIGAFYDE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | Infantile Spasms: 1 month to 2 years of age |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | VITRAKVI |
| ***Drug Names*** | VITRAKVI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | VIZIMPRO |
| ***Drug Names*** | VIZIMPRO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent non-small cell lung cancer (NSCLC) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | VONJO |
| ***Drug Names*** | VONJO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Accelerated or blast phase myeloproliferative neoplasms |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | VOQUEZNA PAK |
| ***Drug Names*** | VOQUEZNA DUAL PAK, VOQUEZNA TRIPLE PAK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For treatment of Helicobacter pylori (H. pylori) infection: the infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility information OR 2) local epidemiology and susceptibility patterns. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 14 days |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | VORANIGO |
| ***Drug Names*** | VORANIGO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | VORICONAZOLE |
| ***Drug Names*** | VORICONAZOLE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The patient will use the requested drug orally or intravenously. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | VOSEVI |
| ***Drug Names*** | VOSEVI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C) |
| ***Required Medical Information*** | For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Criteria will be applied consistent with current AASLD-IDSA guidance. |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | VOTRIENT |
| ***Drug Names*** | PAZOPANIB HYDROCHLORIDE |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Thyroid carcinoma (follicular, papillary, oncocytic, or medullary), uterine sarcoma, chondrosarcoma, gastrointestinal stromal tumor, dedifferentiated liposarcoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For renal cell carcinoma: 1) the disease is advanced, relapsed, or stage IV, OR 2) the requested drug will be used for von Hippel-Lindau (VHL)-associated renal cell carcinoma. For gastrointestinal stromal tumor (GIST): 1) the disease is residual, unresectable, recurrent, or metastatic/tumor rupture AND 2) the patient meets one of the following: a) the disease has progressed after at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib), b) the disease is succinate dehydrogenase (SDH)-deficient GIST. For soft tissue sarcoma (STS): the patient does not have an adipocytic soft tissue sarcoma. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | VOWST |
| ***Drug Names*** | VOWST |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the prevention of recurrence of Clostridioides difficile infection (CDI): 1) The diagnosis of CDI has been confirmed by a positive stool test for C. difficile toxin, AND 2) The requested drug will be administered at least 48 hours after the last dose of antibiotics used for the treatment of recurrent CDI. |
| ***Age Restrictions*** | 18 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 1 month |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | VYVANSE |
| ***Drug Names*** | LISDEXAMFETAMINE DIMESYLA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For attention-deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic central nervous system (CNS) stimulant drug, other than lisdexamfetamine (e.g., amphetamine, dextroamphetamine, methylphenidate). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | WELIREG |
| ***Drug Names*** | WELIREG |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | WINREVAIR |
| ***Drug Names*** | WINREVAIR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than 2 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | WYOST |
| ***Drug Names*** | WYOST |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For hypercalcemia of malignancy: condition is refractory to intravenous (IV) bisphosphonate therapy or there is a clinical reason to avoid IV bisphosphonate therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | XALKORI |
| ***Drug Names*** | XALKORI |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification, recurrent, advanced, or metastatic NSCLC with MET exon 14 skipping mutation, symptomatic or relapsed/refractory anaplastic lymphoma kinase (ALK)-fusion positive Erdheim-Chester Disease, symptomatic or relapsed/refractory (ALK)-fusion positive Rosai-Dorfman Disease, (ALK)-fusion positive Langerhans Cell Histiocytosis, metastatic or unresectable ROS1 gene fusion positive cutaneous melanoma, metastatic or inoperable uterine sarcoma for IMT with ALK translocation |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC), the requested drug is used in any of the following settings: 1) the patient has recurrent, advanced, or metastatic anaplastic lymphoma kinase (ALK)-positive NSCLC, AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following products: Alecensa (alectinib) or Alunbrig (brigatinib), OR 3) the patient has recurrent, advanced, or metastatic ROS-1 positive NSCLC, OR 4) the patient has NSCLC with high-level MET amplification, OR 5) the patient has recurrent, advanced, or metastatic MET exon 14 skipping mutation. For anaplastic large cell lymphoma (ALCL): 1) the disease is relapsed or refractory, AND 2) the disease is ALK-positive. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | XDEMVY |
| ***Drug Names*** | XDEMVY |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | XELJANZ |
| ***Drug Names*** | XELJANZ, XELJANZ XR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderately to severely active rheumatoid arthritis, active ankylosing spondylitis, and active polyarticular course juvenile idiopathic arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (for example, adalimumab, etanercept). For moderately to severely active ulcerative colitis (new starts only): Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (for example, adalimumab). For active psoriatic arthritis (new starts only): 1) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (for example, adalimumab, etanercept) AND 2) the requested drug will be used in combination with a nonbiologic DMARD. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | XERMELO |
| ***Drug Names*** | XERMELO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | XHANCE |
| ***Drug Names*** | XHANCE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 18 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | XIFAXAN |
| ***Drug Names*** | XIFAXAN |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Small intestinal bacterial overgrowth syndrome (SIBO) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For irritable bowel syndrome with diarrhea (IBS-D): 1) The patient has not previously received treatment with the requested drug, OR 2) The patient has previously received treatment with the requested drug, AND a) the patient is experiencing a recurrence of symptoms, AND b) the patient has not already received an initial 14-day course of treatment and two additional 14-day courses of treatment with the requested drug. For small intestinal bacterial overgrowth (SIBO): 1) the patient is experiencing a recurrence after completion of a successful course of treatment with the requested drug OR 2) diagnosis has been confirmed via one of the following: a) quantitative culture of upper gut aspirate, b) breath testing (e.g., lactulose hydrogen or glucose hydrogen breath test). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Reduction in risk of overt HE recurrence: 6 months, IBS-D and SIBO: 14 days |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | XOLAIR |
| ***Drug Names*** | XOLAIR |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderate to severe persistent asthma, initial therapy (tx): 1) Patient (pt) has a positive skin test (or blood test) to at least one perennial aeroallergen, 2) Pt has baseline immunoglobulin E (IgE) level greater than or equal to 30 international units per milliliter (IU/mL), AND 3) Pt has inadequate asthma control despite current tx with both of the following medications: a) Medium-to-high-dose inhaled corticosteroid, AND b) Additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline), unless pt has an intolerance or contraindication to such therapies. For moderate to severe persistent asthma, continuation of tx (COT): Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms (sx) and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For chronic spontaneous urticaria (CSU), initial tx: 1) Pt has been evaluated for other causes of urticaria, including bradykinin-related angioedema and interleukin-1 (IL-1)-associated urticarial syndromes (e.g., auto-inflammatory disorders, urticarial vasculitis), 2) Pt has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks, AND 3) Pt remains symptomatic despite H1 antihistamine treatment. For CSU, COT: Pt has experienced a benefit (e.g., improved sx) since initiation of tx. For chronic rhinosinusitis with nasal polyps (CRSwNP): 1) The requested drug is used as add-on maintenance treatment, AND 2) Pt has experienced inadequate treatment response to Xhance (fluticasone). For IgE-mediated food allergy, initial tx: Pt has baseline IgE level greater than or equal to 30 IU/mL. For IgE-mediated food allergy, COT: Pt has experienced a benefit as evidenced by a decrease in hypersensitivity (e.g., moderate to severe skin, respiratory or gastrointestinal sx) to food allergen. |
| ***Age Restrictions*** | CSU: 12 years of age or older. Asthma: 6 years of age or older. CRSwNP: 18 years of age or older. IgE-mediated food allergy: 1 year of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | CSU initial: 6 months, CSU continuation, All others: Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | XOSPATA |
| ***Drug Names*** | XOSPATA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FLT3 rearrangement, acute myeloid leukemia (AML) post allogeneic hematopoietic cell transplantation (HCT), in remission. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FMS-like tyrosine kinase 3 (FLT3) rearrangement: the disease is in chronic or blast phase. For AML with FLT3 mutation: The requested drug will be used for one of the following: a) relapsed or refractory disease, b) induction therapy, c) post-induction therapy following response to induction therapy with the requested drug, d) consolidation therapy, e) maintenance therapy in patients who are in remission after allogeneic hematopoietic cell transplantation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | XPOVIO |
| ***Drug Names*** | XPOVIO, XPOVIO 60 MG TWICE WEEKLY, XPOVIO 80 MG TWICE WEEKLY |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphoma, high-grade B-cell lymphoma, post-transplant lymphoproliferative disorders |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For multiple myeloma: Patient must have been treated with at least one prior therapy. For B-cell lymphomas: Patient must have been treated with at least two lines of systemic therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | XTANDI |
| ***Drug Names*** | XTANDI |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the treatment of castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer: The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | XTRENBO |
| ***Drug Names*** | XTRENBO |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For hypercalcemia of malignancy: condition is refractory to intravenous (IV) bisphosphonate therapy or there is a clinical reason to avoid IV bisphosphonate therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | XYREM |
| ***Drug Names*** | SODIUM OXYBATE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the treatment of excessive daytime sleepiness in a patient with narcolepsy, initial request: 1) The diagnosis has been confirmed by sleep lab evaluation, AND 2) If the patient is 18 years of age or older, the patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil, modafinil). For the treatment of cataplexy in a patient with narcolepsy, initial request: The diagnosis has been confirmed by sleep lab evaluation. If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy. |
| ***Age Restrictions*** | 7 years of age or older |
| ***Prescriber Restrictions*** | Prescribed by or in consultation with a sleep disorder specialist or neurologist |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | YESINTEK |
| ***Drug Names*** | YESINTEK |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | YONSA |
| ***Drug Names*** | YONSA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | YUTREPIA |
| ***Drug Names*** | YUTREPIA |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1) or pulmonary hypertension (PH) associated with interstitial lung disease (WHO Group 3): the diagnosis was confirmed by right heart catheterization. For new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than 2 Wood units. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ZARXIO |
| ***Drug Names*** | ZARXIO |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN) patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ZEJULA |
| ***Drug Names*** | ZEJULA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Uterine leiomyosarcoma |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For uterine leiomyosarcoma: 1) the requested drug is used as second-line or subsequent therapy AND 2) the patient has BRCA-altered disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ZELBORAF |
| ***Drug Names*** | ZELBORAF |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Non-small cell lung cancer, hairy cell leukemia, central nervous system cancer (i.e., glioma, glioblastoma, pediatric diffuse high-grade glioma), adjuvant or neoadjuvant systemic therapy for cutaneous melanoma, Langerhans cell histiocytosis. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For central nervous system (CNS) cancer (i.e., glioma, glioblastoma, pediatric diffuse high-grade glioma): 1) The tumor is positive for BRAF V600E mutation, AND 2) The requested drug will be used in combination with cobimetinib OR the requested drug is being used for the treatment of pediatric diffuse high-grade glioma. For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) the requested drug will be used as a single agent, or in combination with cobimetinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, or b) adjuvant or neoadjuvant systemic therapy. For Erdheim-Chester Disease and Langerhans Cell Histiocytosis: Tumor is positive for BRAF V600 mutation. For non-small cell lung cancer: 1) The tumor is positive for the BRAF V600E mutation, AND 2) The patient has recurrent, advanced, or metastatic disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ZIRABEV |
| ***Drug Names*** | ZIRABEV |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Ampullary adenocarcinoma, appendiceal adenocarcinoma, central nervous system (CNS) cancers (including pediatric diffuse high-grade gliomas), pleural mesothelioma, peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, vaginal cancer, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ZOLINZA |
| ***Drug Names*** | ZOLINZA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Mycosis fungoides (MF)/Sezary syndrome (SS) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ZONISADE |
| ***Drug Names*** | ZONISADE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For adjunctive treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri, Spritam OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). |
| ***Age Restrictions*** | 16 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

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|---|---|
| ***Prior Authorization Group*** | ZTALMY |
| ***Drug Names*** | ZTALMY |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 2 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | ZURZUVAE |
| ***Drug Names*** | ZURZUVAE |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For the treatment of postpartum depression (PPD): diagnosis was confirmed using standardized rating scales that reliably measure depressive symptoms (e.g., Hamilton Depression Rating Scale [HDRS], Edinburgh Postnatal Depression Scale [EPDS], Patient Health Questionnaire 9 [PHQ9], Montgomery-Asberg Depression Rating Scale [MADRS], Beck's Depression Inventory [BDI], etc.). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 1 month |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

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|---|---|
| ***Prior Authorization Group*** | ZYDELIG |
| ***Drug Names*** | ZYDELIG |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Small lymphocytic lymphoma (SLL) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL): the requested drug is used as second-line or subsequent therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

| | |
|---|---|
| ***Prior Authorization Group*** | ZYKADIA |
| ***Drug Names*** | ZYKADIA |
| ***PA Indication Indicator*** | All FDA-approved Indications, Some Medically-accepted Indications |
| ***Off-label Uses*** | Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), recurrent, advanced, or metastatic ROS1-positive NSCLC, symptomatic or relapsed/refractory Erdheim-Chester Disease (ECD) with ALK-fusion, inflammatory myofibroblastic tumor (IMT) with ALK translocation (including advanced, recurrent/metastatic, or inoperable uterine sarcoma for IMT with ALK translocation), brain metastases from ALK-positive NSCLC, relapsed or refractory ALK-positive anaplastic large cell lymphoma (ALCL) |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): 1) the patient has recurrent, advanced, or metastatic anaplastic lymphoma kinase (ALK)-positive, AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following products: Alecensa (alectinib) or Alunbrig (brigatinib), OR 3) ROS1-positive disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | Yes |

| | |
|---|---|
| ***Prior Authorization Group*** | ZYPREXA RELPREVV |
| ***Drug Names*** | ZYPREXA RELPREVV |
| ***PA Indication Indicator*** | All FDA-approved Indications |
| ***Off-label Uses*** | - |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Tolerability with oral olanzapine has been established. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prerequisite Therapy Required*** | No |

Notice of Availability (NOA) All plans except CA H3038, MA H2224, MA H4371, OH H9955-008

Notice of Availability (NOA) CA Molina Medicare Complete Care (HMO D-SNP) and Molina Medicare Complete Care Plus (HMO D-SNP) Plans

Notice of Availability (NOA) Molina Complete Care for MyCare Ohio (HMO D-SNP) Plan