PA Criteria

Prior Authorization Group	ACITRETIN
Drug Names	ACITRETIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have severe disease. Must have trial of methotrexate or cyclosporine with inadequate response or significant side effect/toxicity or have a contraindication to these therapies. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Dermatologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ACNE PRODUCTS
Drug Names	TAZAROTENE, TRETINOIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Diagnoses not covered: solar elastosis, sun damage, wrinkles, actinic damage, melasma, lentigines / freckles (hyperpigmented macules, liver spots), heliodermatosis, dermatoheliosis
Required Medical Information	Diagnosis. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ACTIMMUNE
Drug Names	ACTIMMUNE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For severe malignant osteopetrosis: must have diagnosis confirmed by radiological evidence.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	For chronic granulomatous disease: by or in consultation with immunologist, hematologist, rheumatologist, or infectious disease physician. For severe malignant osteopetrosis: by or in consultation with orthopedic surgeon, hematologist, endocrinologist or oncologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ACUTE HAE
Drug Names	ICATIBANT ACETATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of HAE. For reauth, must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or under the direction of a HAE specialist (defined as an allergist/immunologist who attests to clinical experience in HAE).
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ADALIMUMAB BIOSIMILAR
Drug Names	HADLIMA, HADLIMA PUSHTOUCH
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Evidence of infection. Use of TNF-blocking or other biologic agent in combination with adalimumab.
Required Medical Information	Negative TB skin test. For plaque psoriasis (PS): must have chronic mod to severe dx. For ankylosing spondylitis (AS), psoriatic arthritis (PsA), and uveitis: must have active dx. For all other dx: must have mod to severely active dx. For RA, JIA: trial of methotrexate (MTX) with inadeq response (if sig. side effects/toxicity or contraindication (CI) to MTX must have trial of hydroxychloroquine for RA or leflunomide or sulfasalazine for RA/JIA). For PsA (peripheral disease): must have trial of 1 NSAID at max tolerated dose and of 1 conventional systemic therapy (e.g. methotrexate, cyclosporine, leflunomide, sulfasalazine) with inadeq responses or sig. side effects/toxicities or have CI to these therapies. For PsA (axial, skin, nail, enthesitis, or dactylitis dominant): must have trial of 2 NSAIDs at max tolerated dose with inadeq response or sig. side effects/toxicities unless CI. For AS: trial of 2 NSAIDs at max tolerated dose with inadeq response or sig. side effects/toxicity or have a CI. For PS: min BSA of at least 3% (not req if on palms, soles, head/neck, genitalia), trial of 1 topical treatment (e.g., corticosteroid, tazarotene gel, calcipotriene oint or sol, tacrolimus oint, pimecrolimus crm) or phototx or photochemotx with inadeq response or sig. side effects/toxicity unless CI, and trial of 1 conventional systemic therapy (e.g. MTX, acitretin, cyclosporine) with inadeq response or sig. side effects/toxicity unless CI. For Crohns, UC: trial of 1 conventional therapy incl corticosteroid, 5-ASA agent (UC only), or immunosuppressant with inadeq response or sig. side effects/toxicity unless CI. For hidradenitis suppurativa (HS): mod or severe dx (w/ 3 active abscesses, inflammatory nodules, or lesions). For uveitis: trial of 1 immunosuppressant (e.g. MTX, mycophenolate, cyclosporine) with inadeq response or sig. side effects/toxicity unless CI. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	JIA: age 2 years or older. Crohns: age 6 years or older. Other dx: age 18 years or older.
Prescriber Restrictions	RA, JIA, ankylosing spondylitis: rheumatologist. Psoriatic arthritis: rheumatologist, dermatologist. Plaque psoriasis, HS: dermatologist. Crohn's, UC: gastroenterologist. Uveitis: ophthalmologist, rheumatologist.
Coverage Duration	HS initial: 90 days. HS reauth: 365 days. All other dx: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	ADEFOVIR
Drug Names	ADEFOVIR DIPIVOXIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Hepatitis B Virus Drug Resistance panel showing resistance to prior tx w/ adefovir
Required Medical Information	Diagnosis. Must have documentation of results of Hep B Virus Drug Resistance panel if previously received antiviral tx regimen for Hep B. Must have documentation of baseline eval and results for following tests: Hep B virus (HBV) DNA viral load, hepatitis B e antigen (HBeAg), antibody to hepatitis B e antigen (anti-HBe), hepatitis B surface antigen (HBsAg), antibody to hepatitis surface antigen (anti-HBs), liver biopsy (if available), alanine aminotransferase (ALT) level and assay reference range. Must have a trial of entecavir with inadequate response, significant side effect/toxicity, contraindication, or documented viral resistance to entecavir or have clinical rationale to support use of adefovir over entecavir. For reauth: must have doc from prescriber indicating continued benefit from tx, doc of recent HBV DNA level, chart doc of HBV Drug Resistance panel if mbr has evidence of virologic breakthrough (greater than 10-fold increase in serum HBV DNA from nadir during tx in mbr who had initial virologic response), and doc of HBeAg/Anti-HBe/HBsAg/Anti-HBs (for mbrs with HBeAg positive and for mbrs with HBeAg negative not falling under any other indications).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Infectious disease physician, gastroenterologist, hepatologist, or transplant physician
Coverage Duration	365 days or until disease progression or clearance
Other Criteria	Regimens/requirements based upon AASLD Practice Guidelines for Chronic Hepatitis B. For HBeAg+ chronic HBV: must meet 1 ALT criterion (ALT greater than or equal to 2xULN OR evidence of moderate/severe inflammation or signif. fibrosis on biopsy) and have HBV DNA level greater than 20,000 IU/mL (not required for pediatric patients if ALT greater than or equal to 2xULN for longer than 6 months). For HBeAg- chronic HBV: must meet 1 ALT criterion (ALT greater than or equal to 2xULN, ALT greater than 1xULN w/ evidence of moderate/severe inflammation or signif. fibrosis on biopsy, ALT less than or equal to ULN w/ ALT increased over time) and 1 HBV DNA criterion (HBV DNA greater than 20,000 IU/mL, HBV DNA greater than 2,000 IU/mL w/ evidence of moderate/severe inflammation or signif. fibrosis on biopsy, HBV DNA less than or equal to 2,000 IU/mL w/ HBV DNA increased over time). For cirrhosis w/ HBV: must have HBV DNA greater than 2,000 IU/mL OR detectable HBV DNA level w/ elevated ALT. For HBV mbr who had liver txfr for HBV or who received solid organ txfr from HBV+ donor: approve regardless of HBV DNA and ALT levels. For HBV carrier who needs immunosuppressive or cytotoxic tx: must be HBsAg+, have planned course of cancer chemo tx or immunosuppressive tx. Reauth for HBeAg+: approve x1 year until all of following are met (loss of HBeAg, undetectable serum HBV DNA, completed 6-12 months of additional tx after appearance of anti-HBe. Reauth for HBeAg-: approve x1 yr until loss of HBsAg. Reauth for cirrhosis, for liver txfr for HBV, or for solid organ txfr from HBV+ donor: long-term tx approvable. Reauth for HBV carriers receiving immunosuppressive or cytotoxic tx: mbr w/ baseline HBV DNA less than 2,000 IU/mL

	should continue x6 months after completion of chemo tx or immunosuppressive tx, mbr w/ baseline HBV DNA greater than 2,000 IU/mL should continue until reach therapeutic endpoints for immunocompetent HBV as listed above.
Prior Authorization Group	AIMOVIG
Drug Names	AIMOVIG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have had one of the following: an inadequate response or intolerance to an antiepileptic drug, beta blocker, or antidepressant unless contraindicated, OR at least 3 months previous treatment with the requested drug with a reduction in migraine days per month from baseline. For reauth: must have documentation of decrease in frequency and/or severity of headaches as a result of therapy.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Neurologist, headache specialist, or pain specialist
Coverage Duration	Initial: 90 days. Reauth: 1 year.
Other Criteria	Not applicable
Prior Authorization Group	ALECENSA
Drug Names	ALECENSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart documentation of lab result confirming ALK mutation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ALOSETRON
Drug Names	ALOSETRON HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Male gender. Constipation. Anatomical or biochemical abnormalities of the gastrointestinal tract. Concomitant use of fluvoxamine. History of chronic or severe constipation or sequelae from constipation, intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state, Crohn's disease or ulcerative colitis, diverticulitis, severe hepatic impairment.
Required Medical Information	Diagnosis. Must have chronic IBS symptoms. Must have chart documentation of how diagnosis was confirmed. Must have trial of loperamide AND an antispasmodic (e.g. dicyclomine) with inadequate response or significant side effect/toxicity or have a contraindication. For reauth: must have documentation from prescriber indicating improvement in condition and no evidence of constipation or ischemic colitis.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Gastroenterologist
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	ALUNBRIG
Drug Names	ALUNBRIG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart documentation of lab result confirming ALK mutation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	AMBRISENTAN
Drug Names	AMBRISENTAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of PAH (WHO Group I) confirmed diagnosis by right heart catheterization. Must have chart documentation of right heart catheterization that indicates the following hemodynamic values: mean pulmonary arterial pressure greater than or equal to 25 mmHg, pulmonary capillary wedge pressure OR left atrial pressure OR left ventricular end-diastolic pressure less than or equal to 15 mmHg, pulmonary vascular resistance greater than 3 Wood units. Must have baseline negative pregnancy prior to initiation of therapy if a female of child-bearing potential. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Cardiologist or pulmonologist. Combination therapy with two or more PAH agents must be prescribed by or in consultation with a pulmonary hypertension specialist.
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	ANDROGENS
Drug Names	METHYLTESTOSTERONE, TESTOSTERONE, TESTOSTERONE CYPIONATE, TESTOSTERONE ENANTHATE, TESTOSTERONE PUMP
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	APTIOM
Drug Names	APTIOM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have had an inadequate response or intolerance to 2 generic antiepileptic drugs (e.g., oxcarbazepine, carbamazepine, lamotrigine, valproic acid, levetiracetam, zonisamide). If using eslicarbazepine as adjunctive therapy to other antiepileptic drugs, cannot be used with oxcarbazepine. Must have documentation of baseline transaminase and bilirubin levels.
Age Restrictions	Age 4 years or older
Prescriber Restrictions	By or in consultation with a neurologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ARANESP
Drug Names	ARANESP ALBUMIN FREE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Uncontrolled hypertension, known hypersensitivity to active substance or any excipients of product.
Required Medical Information	Diagnosis. Must have Hgb less than 10g/dL. For anemia due to chemotx for nonmyeloid malignancy: must have documentation of a minimum of 2 more months of chemotx planned. All dx: Must have iron status evaluated before and during treatment with EPO. Reauth for CKD on dialysis: must have Hgb less than 11g/dL. Reauth for CKD not on dialysis: must have Hgb less than 10g/dL. Reauth for anemia due to chemotx for nonmyeloid malignancy: must have Hgb less than 12g/dL and documentation of a minimum 2 more months of chemotx planned. Reauth for other dx: must have Hgb less than 12g/dL.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a nephrologist, hematologist/oncologist, or transplant physician
Coverage Duration	Initial: 90 days. Reauth: 90 days for chemotx, 180 days for other dx.
Other Criteria	Part B versus Part D determination will made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an ESRD-related condition. If the drug is determined not to be ESRD-related, criteria apply.

Prior Authorization Group	ARCALYST
Drug Names	ARCALYST
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Evidence of infection. Use of TNF-blocking or other biologic agent in combination with rilonacept.
Required Medical Information	Diagnosis. Negative tuberculosis skin test, baseline lipid panel assessment. For Muckle-Wells: must have chart doc of diagnosis confirmed by genetic test (must have documentation of lab result confirming mutation in NLRP3 gene) or a clinical diagnosis (must have 3 of following: autosomal dominant pattern of disease inheritance, presence of severe fatigue, presence of musculoskeletal symptoms, presence of ocular symptoms, presence of erythematous rash, duration of most febrile episodes lasting greater than 24 hours, presence of amyloidosis, presence of hearing loss). For Familial Cold Autoinflammatory Syndrome: must have chart doc of diagnosis confirmed by genetic test (must have documentation of lab result confirming mutation in NLRP3 gene) or a clinical diagnosis (must have 4 of following: recurrent intermittent episodes of fever and rash that primarily follow natural/experimental/both types of generalized cold exposures, autosomal dominant pattern of disease inheritance, age of onset less than 6 months of age, duration of most attacks less than 24 hours, presence of conjunctivitis associated with attacks, absence of deafness/periorbital edema/lymphadenopathy/serositis). For recurrent pericarditis: must have a trial and failure of an NSAID, colchicine, or corticosteroids unless intolerant or contraindicated. For reauth: must have documentation from prescriber indicating improvement in condition and assessment of lipid panel within 3 months (1st reauth) and regularly thereafter.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Rheumatologist, dermatologist, immunologist, cardiologist, or genetic specialist
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	ARIKAYCE
Drug Names	ARIKAYCE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must be used as part of a combination antibacterial drug regimen. Must have failed at least 6 months of treatment with a multidrug regimen. Failure defined as not achieving negative sputum cultures. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	180 days
Other Criteria	Not Applicable

Prior Authorization Group	ARIPIPRAZOLE
Drug Names	ARIPIPRAZOLE, ARIPIPRAZOLE ODT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For Major Depressive Disorder without psychosis, must have adequate trial and failure or inadequate response, duration of at least 4 weeks, or intolerance to monotherapy with 2 different antidepressant therapies (e.g. SSRIs or SNRIs) and must be on concomitant therapy with an SSRI or SNRI as adjunctive treatment (which can include medication from monotherapy trial above)
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ARMODAFINIL
Drug Names	ARMODAFINIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart documentation of sleep study confirming diagnosis for narcolepsy and OSA. Must have trial of modafinil with an inadequate response OR have had a significant side effect/toxicity to modafinil. For narcolepsy: must have trial and failure of CNS stimulant (e.g. amphetamine salts, dextroamphetamine, methylphenidate). For shift-work sleep disorder (SWSD), must meet International Classification of Sleep Disorders criteria for SWSD (either primary complaint of excessive sleepiness or insomnia temporarily associated w/ work period that occurs during habitual sleep phase OR polysomnography and Multiple Sleep Latency Test demonstrate loss of normal sleep-wake pattern, no other medical or mental disorders account for symptoms, and symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness such as time zone change syndrome) and must provide chart documentation of shift work schedule showing 5 or more night shifts per month (defined as at least 4 hours of shift occurring between 10pm and 8am). For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	SWSD: 180 days. Narcolepsy, OSA: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	ASENAPINE
Drug Names	ASENAPINE MALEATE SL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have tried and failed 2 atypical antipsychotics.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	AUVELITY
Drug Names	AUVELITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have a trial and failure or an inadequate response or intolerance to 2 generic formulary antidepressants (e.g., sertraline, citalopram, fluoxetine) unless contraindicated.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	AYVAKIT
Drug Names	AYVAKIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For unresectable or metastatic gastrointestinal stromal tumor (GIST): must have documentation of platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Oncologist, hematologist, allergist, or immunologist
Coverage Duration	365 days
Other Criteria	Not applicable

Prior Authorization Group	B VS. D
Drug Names	ABELCET, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ALBUTEROL SULFATE, AMPHOTERICIN B, AMPHOTERICIN B LIPOSOME, APREPITANT, AZATHIOPRINE, BUDESONIDE, CASPOFUNGIN ACETATE, CINACALCET HYDROCHLORIDE, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX E 2.75%/DEXTROSE, CLINIMIX E 4.25%/DEXTROSE, CLINIMIX E 5%/DEXTROSE 15, CLINIMIX E 5%/DEXTROSE 20, CLINISOL SF 15%, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, EMEND, ENGERIX-B, ENVARSUS XR, GENGRAF, HEPLISAV-B, INTRALIPID, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, LEVALBUTEROL, LEVALBUTEROL HCL, LEVALBUTEROL HYDROCHLORID, METHOTREXATE, METHOTREXATE SODIUM, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, MYHIBBIN, ONDANSETRON HCL, ONDANSETRON HYDROCHLORIDE, ONDANSETRON ODT, PENTAMIDINE ISETHIONATE, PLENAMINE, PREMASOL, PROGRAF, PROSOL, RECOMBIVAX HB, TACROLIMUS, TOBRAMYCIN, TRAVASOL, TROPHAMINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	NA
Other Criteria	-

Prior Authorization Group	BALVERSA
Drug Names	BALVERSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For locally advanced or metastatic urothelial carcinoma: must have 1) susceptible FGFR3 genetic alterations AND 2) progressed during or following at least one line of prior systemic therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	BARBITURATES
Drug Names	PHENOBARBITAL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	BENLYSTA
Drug Names	BENLYSTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Severe active lupus nephritis or severe active central nervous system lupus. Evidence of infection. On concomitant therapy with biologic therapies, including B-cell targeted therapies, or IV cyclophosphamide.
Required Medical Information	Diagnosis. Must be auto-antibody positive, as evidenced through documentation of having one of the following laboratory markers: positive antinuclear antibodies titer greater than or equal to 1:80 or anti-double stranded DNA greater than or equal to 30 IU/mL. Must have trial of hydroxychloroquine, azathioprine, methotrexate, or mycophenolate with inadequate response or significant side effect/toxicity or have a contraindication to these therapies. Must be on concomitant therapy with any of the following (alone or in combination): corticosteroids, antimalarials, NSAIDS, and/or immunosuppressants. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Rheumatologist or nephrologist
Coverage Duration	Initial 180 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	BESREMI
Drug Names	BESREMI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Evidence of infection
Required Medical Information	Must have a baseline platelet count of at least 50,000 cells/mm3 prior to initiation. Must currently require phlebotomy and must have trial of hydroxyurea with an inadequate response or significant side effect/toxicity unless contraindicated.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	BEXAROTENE
Drug Names	BEXAROTENE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist, dermatologist, or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	BOSENTAN
Drug Names	BOSENTAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Current use of glyburide or cyclosporine
Required Medical Information	Diagnosis of PAH (WHO Group I) confirmed diagnosis by right heart catheterization. Must have chart documentation of right heart catheterization that indicates the following hemodynamic values: mean pulmonary arterial pressure greater than or equal to 25 mmHg, pulmonary capillary wedge pressure OR left atrial pressure OR left ventricular end-diastolic pressure less than or equal to 15 mmHg, pulmonary vascular resistance greater than 3 Wood units. Must have WHO Functional Class II-IV symptoms. For adult patients with WHO Functional Class II and III symptoms: must have previous inadequate response or intolerance to ambrisentan. Must have baseline liver function tests (AST, ALT), prior to initiation of therapy. Must have baseline negative pregnancy test prior to initiation of therapy if a female of child-bearing potential. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Cardiologist or pulmonologist. Combination therapy with two or more PAH agents must be prescribed by or in consultation with a pulmonary hypertension specialist.
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	BRAFTOVI AND MEKTOVI
Drug Names	BRAFTOVI, MEKTOVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart documentation of lab result confirming BRAFV600E or BRAFV600K mutation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	BRIVIACT
Drug Names	BRIVIACT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have had an inadequate response or intolerance to two other antiepileptic drugs. Must have an evaluation by a psychiatrist and be followed concurrently by a psychiatrist if the member has a history of psychiatric symptoms including anger, aggression, hostility, irritability, suicidal ideation, and homicidal ideation OR if the member is currently undergoing psychiatric treatment.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a neurologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	BRUKINSA
Drug Names	BRUKINSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For mantle cell lymphoma (MCL): must have received at least one prior therapy. For relapsed or refractory marginal zone lymphoma (MZL): must have received at least one anti-CD20-based regimen.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not applicable

Prior Authorization Group	CABOMETYX
Drug Names	CABOMETYX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For hepatocellular carcinoma: must have been previously treated with sorafenib.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with an oncologist or hematologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	CALQUENCE
Drug Names	CALQUENCE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No exclusion criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	CAPLYTA
Drug Names	CAPLYTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have trial and failure or an inadequate response or intolerance to 2 oral generic atypical antipsychotics.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	CARGLUMIC ACID
Drug Names	CARGLUMIC ACID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Confirmed diagnosis of one of the following: N-acetylglutamate synthase (NAGS) deficiency, N-acetylglutamate (NAG) deficiency, carbamoyl phosphate synthetase 1 (CPS 1) deficiency, propionic acidemia (PA), or methylmalonic acidemia (MMA). Must have chart documentation describing how diagnosis was confirmed (e.g. genetic testing results, enzyme assays, ammonia levels, progress notes, etc.). For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a physician who specializes in the treatment of inherited metabolic disorders.
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	CGRP MIGRAINE AGENTS
Drug Names	NURTEC, QULIPTA, UBRELVY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For preventive treatment of migraine (Nurtec or Qulipta), must have had an inadequate response or intolerance to an antiepileptic drug, beta blocker, or antidepressant unless contraindicated or intolerant. For acute treatment of migraine (Nurtec or Ubrelvy): must have had an inadequate response or intolerance to TWO generic triptans (e.g., sumatriptan, rizatriptan, naratriptan, zolmitriptan) unless contraindicated or intolerant. For reauth: must have documentation of decrease in frequency and/or severity of headaches as a result of therapy.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Neurologist, headache specialist, or pain specialist
Coverage Duration	Initial: 90 days. Reauth: 1 year.
Other Criteria	Not applicable

Prior Authorization Group	CHEMET
Drug Names	CHEMET
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have blood lead level greater than 45 micrograms per deciliter. Must have chart documentation of identification and removal of the cause of lead exposure. For reauth: must meet initial authorization criteria and have clinical rationale from the prescriber for continuation of treatment.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Toxicologist or other clinician who has experience with chelating agents
Coverage Duration	30 days
Other Criteria	Not Applicable

Prior Authorization Group	CLOBAZAM
Drug Names	CLOBAZAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of Lennox-Gastaut syndrome. Must have had an inadequate response or intolerance to 2 generic antiepileptic drugs (e.g. lamotrigine, topiramate, felbamate) and be using clobazam as adjunctive therapy to other anti-epileptic drugs.
Age Restrictions	Age 2 years or older
Prescriber Restrictions	By or in consultation with a neurologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	CLONIDINE ER
Drug Names	CLONIDINE HYDROCHLORIDE E
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of Attention Deficit Hyperactivity Disorder. Must have trial and failure of clonidine (non-extended release) with inadequate response or significant side effects/toxicity unless contraindicated. Must have trial of a CNS stimulant (e.g. methylphenidate, amphetamine salts) with inadequate response or significant side effects/toxicity unless contraindicated. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	COBENFY
Drug Names	COBENFY, COBENFY STARTER PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Urinary retention, Moderate (Child-Pugh Class B) or severe (Child-Pugh Class C) hepatic impairment, Gastric retention, Untreated narrow-angle glaucoma
Required Medical Information	Diagnosis. Must have trial and failure or an inadequate response or intolerance to 2 oral generic atypical antipsychotics
Age Restrictions	Age 18 years or older
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	COPIKTRA
Drug Names	COPIKTRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For treatment of relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic leukemia (SLL): must have tried and failed at least two prior therapies.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	CORLANOR
Drug Names	CORLANOR, IVABRADINE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Blood pressure less than 90/50mmHg. Current acute decompensated heart failure. Sick sinus syndrome, sinoatrial block, or 3rd degree AV block, unless a functioning demand pacemaker is present. Severe hepatic impairment. Dependence on a pacemaker, where heart rate is maintained exclusively by the pacemaker, such as ventricular or atrioventricular pacing more than 40% of the day or demand pacemakers set to a rate greater than 60 beats per minute.
Required Medical Information	Diagnosis. Must currently be taking a beta-blocker (e.g., metoprolol succinate sustained-release, carvedilol, bisoprolol) at maximum tolerated dose for heart failure unless a prior trial with beta-blocker therapy resulted in significant side effect/toxicity or there is a contraindication to use of beta-blocker therapy (e.g., bronchospastic disease such as chronic obstructive pulmonary disease and asthma, severe hypotension or bradycardia). For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Cardiologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	COSENTYX
Drug Names	COSENTYX, COSENTYX SENSOREADY PEN, COSENTYX UNOREADY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Negative TB skin test. For plaque psoriasis (PS): must have chronic moderate to severe dx, must have minimum BSA of at least 5% (not required if on palms, soles, head/neck, genitalia), and must have had an inadequate response, intolerance, or contraindication to Enbrel, Hadlima, Humira, Otezla, or Skyrizi. For psoriatic arthritis: must have had an inadequate response, intolerance, or contraindication to Enbrel, Hadlima, Humira, Otezla, Rinvoq, Skyrizi, or Xeljanz/Xeljanz XR. For ankylosing spondylitis: must have had an inadequate response, intolerance, or contraindication to Enbrel, Hadlima, Humira, Rinvoq, or Xeljanz/Xeljanz XR. For active non-radiographic axial spondyloarthritis: must have had an inadequate response, intolerance, or contraindication to Rinvoq. For juvenile idiopathic arthritis: must have active enthesitis-related disease, and must have had an inadequate response, intolerance, or contraindication to Enbrel, Hadlima, Humira, Rinvoq, or Xeljanz/Xeljanz XR. For hidradenitis suppurativa, must have moderate to severe disease, and must have had an inadequate response, intolerance, or contraindication to Hadlima or Humira. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Juvenile idiopathic arthritis: 4 years or older. Psoriatic arthritis: 2 years or older. Plaque psoriasis: 6 years or older. Ankylosing spondylitis, hidradenitis suppurativa, or non-radiographic axial spondyloarthritis: 18 years or older.
Prescriber Restrictions	Psoriatic arthritis: rheumatologist or dermatologist. Plaque psoriasis or hidradenitis suppurativa: dermatologist. Ankylosing spondylitis, juvenile idiopathic arthritis, or non-radiographic axial spondyloarthritis: rheumatologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	COTELLIC
Drug Names	COTELLIC
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For diagnosis of metastatic melanoma with a BRAF V600E or V600K mutation: must have chart documentation of lab result confirming BRAFV600E or BRAFV600K mutation. For diagnosis of histiocytic neoplasms: no other information required.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	CYSTAGON
Drug Names	CYSTAGON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must confirm that clinical work-up has been performed to rule out other diagnoses. Diagnosis must be confirmed by having all of the following: elevated white blood cell cystine levels greater than 2nmol per 1/2 cystine per mg of protein, laboratory result confirming CTNS gene mutation, and clinical symptoms of nephropathic cystinosis including electrolyte imbalances and polyuria. For reauth: must have documentation from prescriber indicating improvement in condition and a reduction in WBC cystine levels since starting treatment with oral cysteamine.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a nephrologist or physician who specializes in the treatment of inherited metabolic disorders
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	CYSTARAN
Drug Names	CYSTARAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis (dx). Must confirm that clinical work-up has been performed to rule out other dx. Must have chart documentation of elevated baseline white blood cell (WBC) cystine level greater than 1 nmol per 1/2 cystine per mg of protein, laboratory result confirming CTNS gene mutation, clinical symptoms consistent with dx (i.e. photophobia, corneal erosions, keratopathies), AND ophthalmologic exam confirming dx. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with an ophthalmologist or a physician who specializes in the treatment of inherited metabolic disorders.
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	DALFAMPRIDINE
Drug Names	DALFAMPRIDINE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Moderate to severe renal impairment (CrCl less than or equal to 50mL/min), history of seizure, on concomitant therapy with other forms of 4-aminopyridine.
Required Medical Information	Diagnosis. Chart documentation of baseline motor disability or dysfunction. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Neurologist or Physical Medicine and Rehabilitation physician in consultation with the member's treating Neurologist
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	DEFERASIROX
Drug Names	DEFERASIROX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Concomitant advanced malignancy or high-risk myelodysplastic syndrome. Serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance less than 40mL/min.
Required Medical Information	Diagnosis. Must have platelet count greater than or equal to 50,000. For treatment of chronic iron overload due to non-transfusion dependent thalassemia syndromes: must have liver iron concentration of at least 5mg of iron per gram dry weight and serum ferritin greater than 300mcg/L. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Due to transfusions: age 2 years or older. Not due to transfusions: age 10 years or older.
Prescriber Restrictions	Hematologist, oncologist, or hepatologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	DIACOMIT
Drug Names	DIACOMIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have had an inadequate response or intolerance to 2 other antiepileptic drugs (such as valproate and topiramate). Must be used as adjunctive therapy with clobazam.
Age Restrictions	Age 6 months or older
Prescriber Restrictions	By or in consultation with a neurologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	DRONABINOL
Drug Names	DRONABINOL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For chemotherapy induced nausea and vomiting: 1) must be receiving chemotherapy, 2) must have a trial and failure of a 5HT-3 receptor antagonist (e.g., ondansetron) unless intolerant or contraindicated. For AIDS anorexia, patient must have diagnosis of AIDS with anorexia and weight loss. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist, gastroenterologist, or infectious disease physician
Coverage Duration	180 days
Other Criteria	B vs. D determination will be made prior to clinical criteria being applied.

Prior Authorization Group	DROXIDOPA
Drug Names	DROXIDOPA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of symptomatic neurogenic hypotension caused by 1 of following: primary autonomic failure (e.g. Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy. Must have chart doc showing how diagnosis made, incl BP readings showing systolic blood pressure decrease of at least 20mmHg or diastolic blood pressure decrease of at least 10mmHg within 3 minutes of standing. Must have doc that member is symptomatic as result of low BP readings, including doc to support that member is experiencing at least 1 of the following symptoms: dizziness, lightheadedness, feeling faint, feeling like might black out. Must have chart doc indicating d/c or dose decrease of drugs which can cause orthostatic hypotension such as anti-hypertensives, nitrates, alpha-1 blockers (i.e. terazosin, prazosin), antiparkinsonian agents (i.e. levodopa, bromocriptine, ropinirole, pramipexole), diuretics, monoamine oxidase inhibitors, narcotics/tranquilizers/sedatives, drugs for erectile dysfunction, tricyclic antidepressants. Must have a trial of midodrine. For reauth: must have doc from prescriber indicating improvement in condition as evidenced by improvement in the symptoms member was experiencing (i.e. dizziness, lightheadedness, feeling faint, or feeling like might black out) and showing member is being monitored for adverse effects (i.e. supine hypertension) and additional drugs have not been added to the drug regimen that would cause supine hypertension.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Cardiologist or neurologist
Coverage Duration	Initial: 1 month. Reauth: 6 months.
Other Criteria	Not Applicable

Prior Authorization Group	DUAVEE
Drug Names	DUAVEE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Undiagnosed abnormal uterine bleeding. Known, suspected, or past history of breast cancer. Known or suspected estrogen-dependent neoplasia. Active or past history of venous thromboembolism and/or arterial thromboembolism. Known hepatic impairment or disease. Known protein C, protein S, or antithrombin deficiency or other known thrombophilic disorders. Pregnancy, women who may become pregnant, and nursing mothers.
Required Medical Information	Diagnosis. For moderate to severe vasomotor symptoms associated with menopause: must have documentation of clinical rationale for continued use of Duavee (including an explanation of the member's specific benefit of the drug and how that benefit outweighs the potential risk) AND documentation of previous trial of Femring with an inadequate response or significant side effect/toxicity. For osteoporosis prophylaxis: must have trials with a bisphosphonate (e.g. alendronate) and raloxifene with inadequate responses or significant side effects/toxicities unless contraindicated. For vasomotor symptom reauth: must have documentation of clinical rationale for continued use of Duavee (including an explanation of the member's specific benefit of the drug and how that benefit outweighs the potential risk). For osteoporosis reauth: must have documentation indicating continued benefit with use of Duavee.
Age Restrictions	Age 65 years or older: criteria apply. Age less than 65 years: criteria do not apply.
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	DUPIXENT
Drug Names	DUPIXENT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Pending CMS Review
Age Restrictions	Asthma: 6 years of age or older. Atopic Dermatitis: 6 months of age or older. Chronic Rhinosinusitis with Nasal Polyposis, prurigo nodularis: 12 years of age or older. Eosinophilic esophagitis: 1 year of age or older. Bullous Pemphigoid: 18 years or older.
Prescriber Restrictions	Atopic dermatitis, Prurigo nodularis, Bullous Pemphigoid: Prescribed by or in consultation with a dermatologist, allergist, or immunologist. Asthma: Prescribed by or in consultation with a pulmonologist, allergist, or immunologist. Chronic Rhinosinusitis with Nasal Polyposis: Prescribed by or in consultation with an otolaryngologist (ENT), allergist, immunologist, or pulmonologist. Eosinophilic esophagitis: Prescribed by or in consultation with an allergist or gastroenterologist.
Coverage Duration	Initial: 180 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	ENBREL
Drug Names	ENBREL, ENBREL MINI, ENBREL SURECLICK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Evidence of infection. Use of TNF-blocking or other biologic agent in combination with etanercept.
Required Medical Information	Diagnosis. Negative tuberculosis skin test. For RA and JIA: must have diagnosis of moderately to severely active disease, must have trial of methotrexate with inadequate response (if significant side effects/toxicity or contraindication to methotrexate must have trial of hydroxychloroquine, leflunomide, or sulfasalazine for RA and of leflunomide or sulfasalazine for JIA). For psoriatic arthritis (peripheral disease): must have trial of 1 NSAID at max tolerated dose and of 1 conventional systemic therapy (e.g. methotrexate, cyclosporine, leflunomide, sulfasalazine) with inadequate responses or significant side effects/toxicities or have contraindication to these therapies. For psoriatic arthritis (axial, skin, nail, enthesitis, or dactylitis dominant): must have a trial of 2 NSAIDs at max tolerated dose with inadeq response or sig. side effects/toxicities unless contraindicated. For ankylosing spondylitis: must have active disease and must have trial of 2 NSAIDs at max tolerated dose with inadequate response or significant side effects/toxicity or have a contraindication. For plaque psoriasis: must have chronic moderate to severe plaque psoriasis, must have minimum BSA involvement of at least 3% (not required if plaque psoriasis on palms, soles, head/neck, or genitalia), must have trial of 1 topical treatment (e.g., corticosteroid, tazarotene gel, calcipotriene oint or sol, tacrolimus oint, pimecrolimus crm) or phototherapy or photochemotherapy with inadequate response or significant side effects/toxicity or have a contraindication, and must have trial of 1 conventional systemic therapy (e.g. methotrexate, acitretin, cyclosporine) with inadequate response or significant side effects/toxicity or have a contraindication. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	RA, JIA, ankylosing spondylitis: rheumatologist. Psoriatic arthritis: rheumatologist or dermatologist. Plaque psoriasis: dermatologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ENDARI
Drug Names	L-GLUTAMINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have trial and failure, contraindication, or intolerance to hydroxyurea. Failure of hydroxyurea defined as symptoms remaining uncontrolled (e.g., 2 or more sickle cell pain crises within the last 12 months).
Age Restrictions	Age 5 years or older
Prescriber Restrictions	By or in consultation with a hematologist or other sickle cell disease specialist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ENTECAVIR
Drug Names	BARACLUDE, ENTECAVIR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have documentation of results of Hep B Virus Drug Resistance panel if previously received antiviral tx regimen for Hep B. Must have documentation of baseline eval and results for following tests: Hep B virus (HBV) DNA viral load, hepatitis B e antigen (HBeAg), antibody to hepatitis B e antigen (anti-HBe), hepatitis B surface antigen (HBsAg), antibody to hepatitis surface antigen (anti-HBs), liver biopsy (if available), alanine aminotransferase (ALT) level and assay reference range. For reauth: must have doc from prescriber indicating continued benefit from tx, doc of recent HBV DNA level, chart doc of HBV Drug Resistance panel if mbr has evidence or virologic breakthrough (greater than 10-fold increase in serum HBV DNA from nadir during tx in mbr who had initial virologic response), and doc of HBeAg/Anti-HBe/HBsAg/Anti-HBs (for mbrs with HBeAg positive and for mbrs with HBeAg negative not falling under any other indications).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Infectious disease physician, gastroenterologist, hepatologist, or transplant physician
Coverage Duration	365 days or until disease progression or clearance
Other Criteria	Regimens/requirements based upon AASLD Practice Guidelines for Chronic Hepatitis B. For HBeAg+ chronic HBV: must meet 1 ALT criterion (ALT greater than or equal to 2xULN OR evidence of moderate/severe inflammation or signif. fibrosis on biopsy) and have HBV DNA level greater than 20,000 IU/mL (not required for pediatric patients if ALT greater than or equal to 2xULN for longer than 6 months). For HBeAg- chronic HBV: must meet 1 ALT criterion (ALT greater than or equal to 2xULN, ALT greater than 1xULN w/ evidence of moderate/severe inflammation or signif. fibrosis on biopsy, ALT less than or equal to ULN w/ ALT increased over time) and 1 HBV DNA criterion (HBV DNA greater than 20,000 IU/mL, HBV DNA greater than 2,000 IU/mL w/ evidence of moderate/severe inflammation or signif. fibrosis on biopsy, HBV DNA less than or equal to 2,000 IU/mL w/ HBV DNA increased over time). For cirrhosis w/ HBV: must have HBV DNA greater than 2,000 IU/mL OR detectable HBV DNA level w/ elevated ALT. For HBV mbr who had liver txfr for HBV or who received solid organ txfr from HBV+ donor: approve regardless of HBV DNA and ALT levels. For HBV carrier who needs immunosuppressive or cytotoxic tx: must be HBsAg+, have planned course of cancer chemotx or immunosuppressive tx. Reauth for HBeAg+: approve x1 year until all of following are met (loss of HBeAg, undetectable serum HBV DNA, completed 6-12 months of additional tx after appearance of anti-HBe. Reauth for HBeAg-: approve x1 yr until loss of HBsAg. Reauth for cirrhosis, for liver txfr for HBV, or for solid organ txfr from HBV+ donor: long-term tx approvable. Reauth for HBV carriers receiving immunosuppressive or cytotoxic tx: mbr w/ baseline HBV DNA less than 2,000 IU/mL should continue x6 months after completion of chemotx or immunosuppressive tx, mbr w/ baseline HBV DNA greater than 2,000 IU/mL should continue until reach therapeutic

	endpoints for immunocompetent HBV as listed above.
Prior Authorization Group	EPCLUSA
Drug Names	EPCLUSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of chronic Hep C. Doc of prior treatment (tx) for Hep C (if applicable) so that criteria can be applied consistent with current AASLD-IDSA guidance. Chart doc of lab genotype (GT) result, detectable baseline HCV RNA level (incl. assay date, ref. range), test indicating presence or absence of cirrhosis (e.g. F4 score on liver biopsy from within past 3 years, MRI, ultrasound, CT scan).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Infectious disease physician, gastroenterologist, hepatologist, HIV specialist, or transplant physician
Coverage Duration	12 or 24 weeks based on GT, prior tx, presence of cirrhosis
Other Criteria	Regimens/requirements based on AASLD/IDSA Hep C Tx Guidelines found at https://www.hcvguidelines.org/.
Prior Authorization Group	EPIDIOLEX
Drug Names	EPIDIOLEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have had an inadequate response or intolerance to 2 generic antiepileptic drugs (e.g. lamotrigine, topiramate, felbamate).
Age Restrictions	Age 1 years or older
Prescriber Restrictions	By or in consultation with a neurologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	EPOETIN ALFA
Drug Names	RETACRIT
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Uncontrolled hypertension, known hypersensitivity to active substance or any excipients of product.
Required Medical Information	Diagnosis. Initial for ribavirin-induced anemia: must have Hgb less than 10g/dL or a 3g/dL decrease from baseline with anemia symptoms and documentation that dose reduction of ribavirin did not resolve anemia. Initial to reduce risk of allogenic blood transfusions: must have Hgb 10-13g/dL and be at high risk for perioperative transfusion due to significant anticipated blood loss and be scheduled to undergo elective, non-cardiac, or nonvascular surgery. Initial for other dx: must have Hgb less than 10g/dL. Initial for anemia due to chemotx for nonmyeloid malignancy: must have documentation of a minimum 2 more months of chemotx planned. Must have iron status evaluated before and during treatment with EPO. Reauth for CKD on dialysis: must have Hgb less than 11g/dL. Reauth for CKD not on dialysis: must have Hgb less than 10g/dL. Reauth for pediatric CKD: must have Hgb less than 12 g/dL. Reauth for anemia due to chemotx for nonmyeloid malignancy: must have Hgb less than 10g/dL and documentation of a minimum 2 more months of chemotx planned. Reauth for other dx: must have Hgb less than 12g/dL.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a nephrologist, hematologist/oncologist, gastroenterologist, hepatologist, transplant physician, surgeon, or an infectious disease physician
Coverage Duration	Initial: 90 days. Reauth: 90 days for d/t chemotx, 180 days for other dx.
Other Criteria	Part B versus Part D determination will made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an ESRD-related condition. If the drug is determined not to be ESRD-related, criteria apply.

Prior Authorization Group	EPRONTIA
Drug Names	EPRONTIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have a trial and failure of therapy with generic topiramate unless intolerant, contraindicated, or side effects.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ERLOTINIB
Drug Names	ERLOTINIB HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For 1st-line treatment of patients w/ metastatic NSCLC whose tumors have EGFR exon 19 deletions or exon 21 substitution mutations: must have chart documentation of laboratory result confirming EGFR mutation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	EUCRISA
Drug Names	EUCRISA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. No prerequisites required for patients 3 months to 2 years of age. For patients 2 and older: Must have trial and failure of moderate to high potency topical corticosteroid or have a contraindication to this therapy (such as dermatitis on face, genitalia) AND must have trial and failure of topical tacrolimus with inadequate response or significant side effect/toxicity or have a contraindication to this therapy. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	EVEROLIMUS TRANSPLANT
Drug Names	EVEROLIMUS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Must have undergone solid organ transplant.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a transplant specialist
Coverage Duration	365 Days
Other Criteria	B vs. D determination will be made prior to clinical criteria being applied.

Prior Authorization Group	FANAPT
Drug Names	FANAPT, FANAPT TITRATION PACK A
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have trial and failure of risperidone and 1 other atypical antipsychotic (including, but not limited to: aripiprazole, olanzapine, quetiapine, ziprasidone) with inadequate responses or intolerance.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	FETZIMA
Drug Names	FETZIMA, FETZIMA TITRATION PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Concomitant therapy with monoamine oxidase inhibitor, linezolid, or intravenous methylene blue.
Required Medical Information	Diagnosis. Must have trial and failure of one generic serotonin norepinephrine reuptake inhibitor (such as venlafaxine ER) indicated for the treatment of major depressive disorder AND one generic selective serotonin reuptake inhibitor (such as citalopram or fluoxetine). If transitioning from a monoamine oxidase inhibitor to levomilnacipran, must have at least a 14-day washout period in between.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	FILGRASTIM
Drug Names	ZARXIO
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Primary prophylaxis of FN: must be receiving myelosuppressive chemo with greater than 20% FN risk OR non-myelosuppressive chemo (less than or equal to 20% FN risk) and considered high risk for chemo-induced FN or infection with at least 1 risk factor (see other criteria) OR dose-dense chemo for tx of node + breast ca, small-cell lung ca, or diffuse aggressive Non-Hodgkin's Lymphoma. Secondary prophylaxis of FN: must have experienced neutropenic complication from prior chemo cycle for which primary prophylaxis not received and in which reduced dose may compromise disease-free or overall survival or tx outcome. Tx of febrile pts w/ neutropenia: must have fever and neutropenia and be at high risk for infection-related complications or have prognostic factors predictive of poor clinical outcomes, have at least one risk factor (see other criteria), AND not have received prophylactic pegfilgrastim during current chemo cycle. Bone marrow txfr: must be used after autologous peripheral blood progenitor cell transplant OR mobilization of progenitor cells into peripheral blood (often in conjunction with chemo) for collection by leukapheresis. AML: must be receiving induction or consolidation tx. ALL: must be using after completion of initial 1st few days of chemo of initial induction or 1st post-remission course. Myelodysplastic syndrome: must have severe neutropenia and recurrent infection. Pts receiving radiation: must be receiving radiation tx w/o concomitant chemo w/ expected prolonged delays due to neutropenia. Older lymphoma pts: must have dx of acute aggressive lymphoma tx w/ curative chemo (CHOP or more aggressive regimen). Congenital, cyclic, or idiopathic neutropenia: must have symptomatic neutropenia. Drug-induced agranulocytosis: must have severe neutropenia w/ fever or serious infection as result of myelosuppressive regimen. For reauth: must have doc from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	90 days
Other Criteria	% risk of FN based on ASCO or NCCN guidelines. Risk factors for primary prophy of FN: age 65 years or older, poor performance status, previous episode of FN, extensive prior treatment including large radiation ports, previous chemotherapy or radiation therapy, pre-existing neutropenia, cytopenia due to bone marrow involvement by tumor, poor nutritional status, presence of open wounds or active infection, recent surgery, advanced cancer, liver dysfunction such as elevated bilirubin, or other serious comorbidities. Risk factors for tx of febrile pts w/ neutropenia: sepsis syndrome, expected prolonged neutropenia for greater than 10 days, severe neutropenia with ANC less than 100/microliter, age 65 years or older, uncontrolled primary disease, pneumonia, hypotension and multi-organ dysfunction (sepsis syndrome), invasive fungal infection, other clinically documented infections, hospitalization at time of fever,

	prior episode of febrile neutropenia. For treatment of febrile patients w/ neutropenia: must not have received pegfilgrastim during current chemotx cycle.
Prior Authorization Group	FINTEPLA
Drug Names	FINTEPLA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have had an inadequate response or intolerance to 2 other antiepileptic drugs (such as valproate and topiramate).
Age Restrictions	Age 2 years or older
Prescriber Restrictions	By or in consultation with a neurologist
Coverage Duration	365 days
Other Criteria	Not Applicable
Prior Authorization Group	FIRST GENERATION ANTIHISTAMINES
Drug Names	CYPROHEPTADINE HCL, CYPROHEPTADINE HYDROCHLOR, HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE, HYDROXYZINE PAMOATE, PROMETHAZINE HYDROCHLORID, PROMETHEGAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Approve cyproheptadine, hydroxyzine, and promethazine if prior trial and failure, intolerance, toxicity or contraindication of levocetirizine for allergic rhinitis, allergic conditions, or urticaria. Approve promethazine if prior trial and failure, intolerance, toxicity or contraindication of ondansetron for nausea and vomiting. Approve hydroxyzine if prior trial and failure, intolerance, toxicity or contraindication of two therapies (such as SSRIs and SNRIs) for anxiety. For all other FDA-approved indications, no prior drug trials are required.
Age Restrictions	Age 65 years or older: criteria apply. Age less than 65 years: criteria do not apply.
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	FOTIVDA
Drug Names	FOTIVDA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have documentation of a previous trial and failure of at least two systemic therapies for renal cell carcinoma.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	FYCOMPA
Drug Names	FYCOMPA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have had an inadequate response or intolerance to 2 other antiepileptic drugs (such as carbamazepine, oxcarbazepine, or phenytoin). Must have documentation indicating the member will be monitored for the psychiatric side effects of perampanel. For reauth: must have documentation from prescriber indicating improvement in condition and monitoring for psychiatric side effects.
Age Restrictions	Age 4 years or older
Prescriber Restrictions	Neurologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	GAVRETO
Drug Names	GAVRETO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Chart documentation of diagnosis with an FDA approved test
Age Restrictions	Age 12 years or older
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	GEFITINIB
Drug Names	GEFITINIB
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart documentation of lab result confirming epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	GILOTRIF
Drug Names	GILOTRIF
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For first line treatment of metastatic non-small cell lung cancer, must have chart documentation of lab result confirming non-resistant epidermal growth factor receptor (EGFR) mutations. Documentation of mutation(s) not required for treatment of metastatic, squamous NSCLC progressing after platinum-based chemotherapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	GLP-1 AGONISTS
Drug Names	MOUNJARO, OZEMPIC, RYBELSUS, TRULICITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	GRALISE
Drug Names	GRALISE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of Postherpetic Neuralgia. Must have trial and failure of tricyclic antidepressant unless contraindicated. Must have trial and failure of gabapentin defined as either failure due to insufficient efficacy at dose of at least 1800mg/day OR chart documented failure due to intolerance despite slow dose titration.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	GROWTH HORMONE
Drug Names	GENOTROPIN, GENOTROPIN MINIQUICK
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Active malignancy in the past year. Active proliferative or severe non-proliferative diabetic retinopathy. For Prader-Willi: severely obese (BMI greater than or equal to 97th percentile for age/gender or BMI greater than or equal to 35), history of upper airway obstruction or sleep apnea, or severe respiratory impairment.
Required Medical Information	Diagnosis. All dx: chart doc of present height, %, height SD score, pre-tx growth velocity (initial auth), growth velocity on tx (reauth), recent skeletal bone age. Classic growth hormone deficiency (GHD): names/dates of specific GH stim tests, history of irradiation or multiple pituitary hormone deficiency. For chronic renal insufficiency (CRI): estimated date of renal transplant (txfr). Prader-Willi: BMI. For child born small for gestational age (SGA): GA, birth weight and length, height or weight % or SD at birth. Child w/ SHOX deficiency: chart doc of lab of SHOX mutation. Child w/ idiopathic short stature (ISS): doc of growth rates unlikely to permit attainment of adult height w/i target range based on parental heights. Adults: doc of GHD during childhood and cause of GHD (if applicable), serum IGF-I level while not on GH (if applicable), names and dates of specific GH stim tests (if applicable), whether there is pituitary adenoma (and if so, if tumor size has remained stable x1 yr), doc of possible cause of GH deficiency (severe GH deficiency as child d/t genetic cause, severe GH and receipt of high-dose cranial radiation tx, structural hypothalamic-pituitary disease, CNS tumor, deficiencies in pituitary hormones such as ACTH/TSH/prolactin/gonadotropins/arginine vasopressin). GH stim tests accepted for adults: insulin tolerance test (ITT) required unless contraind (pts w/ known or at high risk for CAD, hx of seizures, severe panhypopituitarism/hypoadrenalism) w/ neg response of peak GH less than or equal to 5ug/L, if ITT contraind glucagon test req unless contraind (malnourished or have not eaten in 48 hrs, pheochromocytoma, insulinoma, severe hypocortisolemia) w/ neg response of peak GH less than or equal to 3ug/L, if ITT and glucagon contraind arginine test req w/ neg response of peak GH less than or equal to 0.4ug/L.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Endocrinologist, nephrologist, pediatric endocrinologist, or pediatric nephrologist dependent upon diagnosis.
Coverage Duration	Idiopathic short stature: 180 days. Other dx: 365 days.
Other Criteria	Child w/ Classic GHD: must have doc of failure to respond to 2 GH provocative tests (1 test if h/o irradiation or multiple pituitary hormone deficiency) w/ serum peak GH level less than 10ng/mL on stim tests (insulin, levodopa, arginine, clonidine, glucagon), must have at least 2 of following (present height less than 3rd % or greater than 2 SD below mean for gender/age, pre-tx growth velocity less than 7cm/yr for child less than 3 yrs OR less than 4cm for child 3 yrs and older OR less than 10th % for gender/age based on at least 6 months of growth data for child of any age, comparison of skeletal/bone age by x-ray of left hand and wrist greater than 2 SD below chronological age). Growth retardation d/t CRI, Prader-Willi Syndrome, SHOX Deficiency: documented dx of CRI

	up to time of renal txfr (CRI only), must have at least 1 of following (present height less than 3rd % or greater than 2 SD below mean for gender/age, pre-tx growth velocity less than 7cm/yr for child less than 3 yrs OR less than 4cm for child 3 yrs and older OR less than 10th % for gender/age based on at least 6 months of growth data for child of any age). Turner's Syndrome (females), Noonan Syndrome (males, females), must have 1 of following: present height less than 5th % or greater than 2 SD below mean for gender/age, pre-tx growth velocity less than 7cm/yr for child less than 3 yrs OR less than 4cm for child 3 yrs and older OR less than 10th % for gender/age based on at least 6 months of growth data for child of any age. ISS: must have height SD score of less than -2.25cm/yr. SGA: must have low birth weight (either birth weight less than 2500g at GA of more than 37 wks OR birth weight and length less than 3rd % or less than -2 SD for GA), must have failed to achieve catch-up growth by ages 2-4 with baseline pre-tx height SD score less than -2.5 SD for age/gender. Adult w/ GHD, childhood onset: must stop GH tx x1 mon after completion of linear growth and have GH levels reassessed (not req if high likelihood of GHD defined as IGF-1 less than 84ug/L while off GH tx AND at least 1 of following: severe GHD as child d/t genetic cause, structural hypothalamic-pituitary disease, CNS tumors, severe GHD and receipt of high-dose cranial radiation tx, deficiencies in at least 3 pituitary hormones), must have GHD reassessed w/ 1 GH stim test if IGF-1 less than 84ug/L while not on GH tx and w/ 2 GH stim tests if IGF-1 normal while not on GH tx. Adult w/ GHD, adult onset: if panhypopituitarism GH stim test not required if pt has deficiencies in at least 3 pituitary hormones and IGF-1 less than 84ug/L while not on GH tx, if no panhypopituitarism w/ low IGF-1 must have GH deficiency confirmed by 2 GH stim tests. For child reauth: d/c if growth velocity on GH tx less than 2.5cm/yr, reached adult height, growth plates fused, need for renal txfr (for CRI), bone age of 14 in females and 16 in males. For any age: must have doc from prescriber indicating improvement in condition.
Prior Authorization Group	HARVONI
Drug Names	HARVONI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of chronic Hep C. Doc of prior treatment (tx) for Hep C (if applicable) so that criteria can be applied consistent with current AASLD-IDSA guidance. Chart doc of lab genotype (GT) result, detectable baseline HCV RNA level (incl. assay date, ref. range), test indicating presence or absence of cirrhosis (e.g. F4 score on liver biopsy from within past 3 years, MRI, ultrasound, CT scan).
Age Restrictions	Age 3 years or older
Prescriber Restrictions	Infectious disease physician, gastroenterologist, hepatologist, HIV specialist, or transplant physician
Coverage Duration	12 or 24 weeks based on GT, prior tx, presence of cirrhosis
Other Criteria	Regimens/requirements based on AASLD/IDSA Hep C Tx Guidelines found at https://www.hcvguidelines.org/.

Prior Authorization Group	HIGH RISK ANTIDEPRESSANTS
Drug Names	AMITRIPTYLINE HCL, AMITRIPTYLINE HYDROCHLORI, AMOXAPINE, CLOMIPRAMINE HYDROCHLORID, DOXEPIN HCL, DOXEPIN HYDROCHLORIDE, IMIPRAMINE HCL, IMIPRAMINE HYDROCHLORIDE, IMIPRAMINE PAMOATE, NORTRIPTYLINE HCL, NORTRIPTYLINE HYDROCHLORI, PAROXETINE HCL, PAROXETINE HYDROCHLORIDE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Approve amitriptyline, amoxapine, clomipramine, doxepin (doses higher than 6mg/day), imipramine, imipramine pamoate, nortriptyline, or paroxetine if prior trial and failure of 2 of following for depression: SSRIs, venlafaxine, venlafaxine ER capsules, trazodone, mirtazapine, bupropion. Approve clomipramine if prior trial and failure of 2 of following for obsessive-compulsive disorder: citalopram, escitalopram, fluoxetine, fluvoxamine, sertraline, venlafaxine, venlafaxine ER capsules. Approve doxepin for urticaria/pruritus if prior trial and failure of levocetirizine. For all other FDA-approved indications, no prior drug trials are required.
Age Restrictions	Age 65 years or older: criteria apply. Age less than 65 years: criteria do not apply.
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	HIGH RISK BENZODIAZEPINES
Drug Names	CLORAZEPATE DIPOTASSIUM, DIAZEPAM, DIAZEPAM INTENSOL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have attestation from prescriber assessing the risks and benefits of therapy and desire to prescribe drug.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	HORIZANT
Drug Names	HORIZANT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For RLS: must have trial and failure of pramipexole or ropinirole (defined as insufficient efficacy of pramipexole 0.5mg per day or ropinirole 4mg per day or intolerance to these meds) AND must have trial and failure of gabapentin (defined as insufficient efficacy of gabapentin 1800mg per day or intolerance to med despite slow dose titration or contraindication). For PHN: must have trial and failure of gabapentin (defined as insufficient efficacy of gabapentin 1800mg per day or intolerance to med despite slow dose titration or contraindication) AND must have trial of tricyclic antidepressant unless intolerant or contraindicated. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	HUMIRA
Drug Names	HUMIRA, HUMIRA PEDIATRIC CROHNS D, HUMIRA PEN, HUMIRA PEN-CD/UC/HS START, HUMIRA PEN-PS/UV STARTER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Evidence of infection. Use of TNF-blocking or other biologic agent in combination with adalimumab.
Required Medical Information	Negative TB skin test. For plaque psoriasis (PS): must have chronic mod to severe dx. For ankylosing spondylitis (AS), psoriatic arthritis (PsA), and uveitis: must have active dx. For all other dx: must have mod to severely active dx. For RA, JIA: trial of methotrexate (MTX) with inadeq response or sig. side effects/toxicity or contraindication (CI). For AS: trial of 2 NSAIDs at max tolerated dose with inadeq response or sig. side effects/toxicity or have a CI. For PS: min BSA of at least 3% (not req if on palms, soles, head/neck, genitalia), trial of 1 topical treatment (e.g., corticosteroid, tazarotene gel, calcipotriene oint or sol, tacrolimus oint, pimecrolimus crm) or phototx or photochemotx with inadeq response or sig. side effects/toxicity unless CI, and trial of 1 conventional systemic therapy (e.g. MTX, acitretin, cyclosporine) with inadeq response or sig. side effects/toxicity unless CI. For Crohns, UC: trial of 1 conventional therapy incl corticosteroid, 5-ASA agent (UC only), or immunosuppressant with inadeq response or sig. side effects/toxicity unless CI. For hidradenitis suppurativa (HS): mod or severe dx (w/ 3 active abscesses, inflammatory nodules, or lesions). For uveitis: trial of 1 immunosuppressant (e.g. MTX, mycophenolate, cyclosporine) with inadeq response or sig. side effects/toxicity unless CI. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	JIA, uveitis: age 2 years or older. Crohns: age 6 years or older. HS: age 12 years or older. Ulcerative colitis: age 5 years or older. Other dx: age 18 years or older.
Prescriber Restrictions	RA, JIA, ankylosing spondylitis: rheumatologist. Psoriatic arthritis: rheumatologist, dermatologist. Plaque psoriasis, HS: dermatologist. Crohns, UC: gastroenterologist. Uveitis: ophthalmologist, rheumatologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	HYPNOTICS
Drug Names	ZOLPIDEM TARTRATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have a previous trial and failure of therapy with trazodone, Rozerem, or Silenor unless intolerant or contraindicated.
Age Restrictions	Age 65 years or older: criteria apply. Age less than 65 years: criteria do not apply.
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	IDHIFA
Drug Names	IDHIFA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have documentation of laboratory result confirming an isocitrate dehydrogenase-2 (IDH2) mutation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	IMBRUVICA
Drug Names	IMBRUVICA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For chronic graft vs host disease (cGVHD): must have tried and failed at least one line of systemic therapy (examples may include corticosteroids, cyclosporine, tacrolimus).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist, hematologist, or transplant specialist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	IMMUNE GLOBULINS
Drug Names	GAMUNEX-C
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Primary immunodeficiency: IgG less than 500mg/dL (clinical rationale for use required if IgG is 500mg/dL or greater) and history of at least 1 bacterial infection directly attributable to deficiency for initial auth and recent IgG level for reauth. Children w/ ITP: platelet count less than: 20,000 and significant mucous membrane bleeding, 10,000 and minor purpura, or 20,000 and inaccessibility or noncompliance is concern, OR need for any surgery, dental extraction, or other procedure likely to cause blood loss. Adults w/ ITP: plt count less than 30,000 and previous documented inadequate response or intolerance to corticosteroids OR need for surgery likely to cause blood loss (platelet count less than or equal to: 10,000 for dentistry, 30,000 for tooth extraction or regional dental block, 50,000 for minor surgery, 80,000 for major surgery). For pregnant women w/ ITP: plt count less than 100,000, history of splenectomy, or previous delivery of infant(s) w/ autoimmune thrombocytopenia. B-Cell CLL: IgG less than 500mg/dL and previous history of serious bacterial infection requiring antibiotics. CIDP: doc of electrodiagnostic testing confirming dx. Multifocal Motor Neuropathy: must have conduction block and progressive symptomatic disease diagnosed on basis of electrophysiologic findings to r/o other possible conditions. For reauth (all dx): must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Primary immunodeficiency: by or in consultation w/ immunologist, hematologist. ITP: hematologist, oncologist. B-cell CLL: hematologist, oncologist, ID specialist. CIDP, Multifocal Motor Neuropathy: neurologist.
Coverage Duration	ITP: 30 days. CIDP, multifocal motor neuropathy: 90 days. Other dx: 365 days.
Other Criteria	BvsD determination will be made prior to clinical criteria being applied.

Prior Authorization Group	IMPAVIDO
Drug Names	IMPAVIDO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	Age 12 years or older
Prescriber Restrictions	Infectious disease provider
Coverage Duration	28 days
Other Criteria	Not Applicable

Prior Authorization Group	INCRELEX
Drug Names	INCRELEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Closed epiphyses, presence of active or suspected neoplasia, allergy to mecasermin, current treatment with growth hormone replacement therapy, secondary forms of IGF-1 deficiency (e.g. growth hormone deficiency, malnutrition not corrected prior to start of mecasermin, hypothyroidism not corrected prior to start of mecasermin, chronic treatment with pharmacological dose of anti-inflammatory steroids)
Required Medical Information	Diagnosis. For growth hormone deletion: must have growth hormone (GH) gene deletion in gene GH1 and developed neutralizing antibodies to GH therapy. For growth failure due to severe IGF-1 deficiency: must have dx of severe IGF-1 deficiency (defined as having all of the following: height standard deviation (SD) score less than or equal to -3.0 for age and sex, basal IGF-1 SD of less than or equal to -3.0 based on lab reference range, normal or elevated GH defined as stimulated serum GH level of greater than 10ng/mL or basal serum GH level greater than 5ng/mL). For reauth, must have documentation of recent progress note from prescriber indicating growth and maturation as a result of treatment and that epiphyses have not closed.
Age Restrictions	Age 2 years or older
Prescriber Restrictions	Endocrinologist with appropriate endocrinologist follow-up.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	INREBIC
Drug Names	INREBIC
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have a baseline platelet count of at least 50,000 cells/mm3 prior to initiation of fedratinib.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	INSULIN SUPPLIES
Drug Names	-
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Use for any indication other than the delivery of insulin.
Required Medical Information	Verification supplies are associated with the injection of insulin.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No prescriber restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	INTRAVENOUS ANTIBIOTICS
Drug Names	AMPICILLIN SODIUM, AZITHROMYCIN, AZTREONAM, CEFOTETAN, CEFOXITIN SODIUM, CEFUROXIME SODIUM, CIPROFLOXACIN I.V.-IN D5W, CLINDAMYCIN PHOSPHATE/DEX, COLISTIMETHATE SODIUM, DOXY 100, ERYTHROCIN LACTOBIONATE, LINEZOLID, METRONIDAZOLE, MOXIFLOXACIN HYDROCHLORID, NAFCILLIN SODIUM, OXACILLIN SODIUM, PENICILLIN G POTASSIUM, PENICILLIN G POTASSIUM IN, PENICILLIN G SODIUM, PENTAMIDINE ISETHIONATE, POLYMYXIN B SULFATE, TEFLARO, TIGECYCLINE, VANCOMYCIN HCL, VANCOMYCIN HYDROCHLORIDE, ZERBAXA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	ITRACONAZOLE
Drug Names	ITRACONAZOLE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For dermatological mycoses: must be too large to treat with topical antifungals, or have not responded, had an intolerance or contraindication to at least 1 topical antifungal agent (e.g. ciclopirox, clotrimazole, ketoconazole, or nystatin). For onychomycosis: must have trial and failure, intolerance, or contraindication to 1 course (3 months) of oral terbinafine. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	IVERMECTIN
Drug Names	IVERMECTIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	JAKAFI
Drug Names	JAKAFI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Evidence of infection
Required Medical Information	Diagnosis of intermediate or high-risk myelofibrosis (includes primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis). Must have a baseline platelet count of at least 50,000 cells/mm3 prior to initiation of ruxolitinib. For diagnosis of polycythemia vera: must currently require phlebotomy and must have trial of hydroxyurea with an inadequate response or significant side effect/toxicity unless contraindicated. For diagnosis of acute graft-versus-host disease: no other information required.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist, hematologist, or transplant specialist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	JUXTAPID
Drug Names	JUXTAPID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Members who are pregnant, who have moderate or severe hepatic impairment (Child-Pugh category B or C) or active liver disease, or who are on concomitant moderate or strong CYP3A4 inhibitors.
Required Medical Information	Diagnosis of homozygous familial hypercholesterolemia confirmed by genetic testing with functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality or have clinical diagnosis defined as one of the following (1) untreated LDL greater than 500mg/dL AND untreated total cholesterol (TC) greater than 500mg/dL and triglycerides (TG) less than 300mg/dL with both parents with untreated TC greater than 250mg/dL, (2) skin fibroblast LDL receptor activity less than 20% of normal AND untreated TC greater than 500mg/dL and TG less than 300mg/dL with both parents with untreated TC greater than 250mg/dL, (3) presence of cutaneous and tendon xanthomas and corneal arcus in first decade of life AND untreated TC greater than 500mg/dL and TG less than 300mg/dL with both parents with untreated TC greater than 250mg/dL, (4) untreated LDL greater than 500mg/dL AND skin fibroblast LDL receptor activity less than 20% of normal, (5) untreated LDL greater than 500mg/dL AND presence of cutaneous and tendon xanthomas and corneal arcus in first decade of life. Must have chart documentation of clinical work-up to rule out other diagnoses. For initial auth: baseline negative pregnancy test with date of test and be on effective contraception for females of reproductive potential, and baseline laboratory monitoring of LDL, total cholesterol, triglycerides, transaminases, alkaline phosphatase, and bilirubin with date of test. Must be on statin (e.g. atorvastatin, simvastatin) unless intolerant or contraindicated and another LDL-lowering medication from a different class (e.g. ezetimibe, colestipol) prior to starting lomitapide. For reauth: documentation from prescriber indicating improvement in condition, documentation of follow-up LDL levels showing reduction in LDL level since starting treatment, and documentation of monitoring of transaminase, alkaline phosphatase, and bilirubin levels.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Lipidologist, cardiologist, endocrinologist, or geneticist
Coverage Duration	Initial: 120 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	KALYDECO
Drug Names	KALYDECO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Documentation of lab result confirming at least one copy of a mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data. Baseline percent of predicted FEV1. For reauth: must have documentation from prescriber showing member benefit from treatment, clinical rationale to support continuation of therapy, and current percent predicted FEV1.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Pulmonologist or cystic fibrosis specialist
Coverage Duration	Initial: 180 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	KERENDIA
Drug Names	KERENDIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must be using concurrently with maximally tolerated dose of an ACE inhibitor (e.g., lisinopril) or ARB (e.g., losartan) unless intolerant or contraindicated.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 Days
Other Criteria	Not Applicable

Prior Authorization Group	KISQALI
Drug Names	KISQALI, KISQALI FEMARA 400 DOSE, KISQALI FEMARA 600 DOSE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must be used in combination with an aromatase inhibitor as initial endocrine-based therapy or fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy for advanced or metastatic disease AND must have a medical reason as to why Ibrance (palpociclib) and Verzenio (abemaciclib) cannot be utilized.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	LAPATINIB
Drug Names	LAPATINIB DITOSYLATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. ECOG Performance Status.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	LEUPROLIDE AND DERIVATIVES
Drug Names	ELIGARD, FIRMAGON, LEUPROLIDE ACETATE, LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH), LUPRON DEPOT (4-MONTH), LUPRON DEPOT (6-MONTH), SYNAREL, TRELSTAR MIXJECT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For endometriosis: must have diagnosis confirmed by laparoscopy OR chart documentation of clinical work-up and clinical rationale for diagnosis, and must have trial and failure of oral contraceptives and/or progestins for mild disease. For fibroids: must be used preoperatively to maximize hemoglobin in patients with documented anemia (Hgb less than 11g/dL), or preoperatively to decrease size of fibroid uterus so less invasive route of hysterectomy can be attempted, or must provide clinical rationale if using outside context of preoperative adjuvant therapy in the surgical management of fibroids. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	Cancer, central precocious puberty: 365 dys. Endometriosis: 180 dys. Fibroid: 90 dys.
Other Criteria	Not Applicable

Prior Authorization Group	LIDOCAINE PATCH
Drug Names	LIDOCAINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	LONG ACTING OPIOIDS
Drug Names	FENTANYL, MORPHINE SULFATE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have trial of a short acting opioid with inadequate response or significant side effect/toxicity or have a contraindication to these therapies.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 Days
Other Criteria	Not Applicable

Prior Authorization Group	LONSURF
Drug Names	LONSURF
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. ECOG Performance Status.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	LUMAKRAS
Drug Names	LUMAKRAS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Chart documentation of lab results confirming KRAS G12C-mutation.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not applicable

Prior Authorization Group	LURASIDONE
Drug Names	LURASIDONE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have a trial and failure or an inadequate response or intolerance to 2 generic antipsychotics (e.g., haloperidol, fluphenazine, chlorpromazine, perphenazine, aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	LYBALVI
Drug Names	LYBALVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have tried and failed 2 atypical antipsychotics.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

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 class B or C)
Required Medical Information	Diagnosis of chronic or acute Hep C. Doc of prior treatment (tx) for Hep C (if applicable) so that criteria can be applied consistent with current AASLD-IDSA guidance. Chart doc of lab genotype (GT) result, detectable baseline HCV RNA level (incl. assay date, ref. range), test indicating presence or absence of cirrhosis (e.g. F4 score on liver biopsy from within past 3 years, MRI, ultrasound, CT scan).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Infectious disease physician, gastroenterologist, hepatologist, HIV specialist, or transplant physician
Coverage Duration	8-16 weeks
Other Criteria	Regimens/requirements based on AASLD/IDSA Hep C Tx Guidelines found at https://www.hcvguidelines.org/.

Prior Authorization Group	MEGESTROL
Drug Names	MEGESTROL ACETATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist, hematologist, or HIV specialist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	MEKINIST
Drug Names	MEKINIST
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Treatment with prior BRAF-inhibitor therapy if using trametinib as monotherapy
Required Medical Information	Diagnosis. For unresectable, metastatic, or completely resected melanoma: must have chart documentation of lab result confirming BRAFV600E or BRAFV600K mutation. For metastatic non-small cell lung cancer or locally advanced or metastatic anaplastic thyroid cancer: must have chart documentation of lab result confirming BRAFV600E mutation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	MEMANTINE
Drug Names	MEMANTINE HCL TITRATION P, MEMANTINE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of moderate to severe dementia of Alzheimer's type. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Must be age 18 or older. Age 18 to 40 years: criteria apply. Age greater than 40 years: criteria do not apply.
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	METHAMPHETAMINE
Drug Names	METHAMPHETAMINE HYDROCHLO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Age 6 years or older
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	METHOTREXATE SOLUTION
Drug Names	JYLAMVO, XATMEP
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have had an inadequate response or intolerance to generic methotrexate.
Age Restrictions	Xatmep: 17 years or less, Jylamvo: 18 years or older
Prescriber Restrictions	No prescriber restrictions
Coverage Duration	365 days
Other Criteria	B vs. D determination will be made prior to clinical criteria being applied.

Prior Authorization Group	MIFEPRISTONE
Drug Names	MIFEPRISTONE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Pregnant. History of unexplained vaginal bleeding, endometrial hyperplasia with atypia, or endometrial carcinoma. Concomitant therapy with simvastatin, lovastatin, or CYP3A4 substrates with narrow therapeutic range (i.e. cyclosporine, tacrolimus). Concurrent long-term corticosteroid treatment.
Required Medical Information	Diagnosis. Must have failed surgery or not be a candidate for surgery (trans-sphenoidal surgery for pituitary dependent Cushing's or surgical removal of an adrenocortical tumor or a source of ectopic ACTH in malignant Cushing's). Female members of reproductive potential: must have baseline (within previous month, must include date of test) negative pregnancy test prior to starting mifepristone and must be using non-hormonal medically acceptable method of contraception (unless surgically sterilized) during treatment and for 1 month after mifepristone therapy. Must have baseline hemoglobin A1C level. For reauth: must have documentation from prescriber indicating improvement in condition, must have documentation of recent (within previous month) negative pregnancy test including date of test if female of reproductive potential, and must have documentation of improvement in hyperglycemia control as evidenced by a reduction in blood glucose levels, HbA1c, or anti-hyperglycemic medication doses or number of medications.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	By or in consultation with an endocrinologist
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	MODAFINIL
Drug Names	MODAFINIL
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Chart documentation of sleep study confirming diagnosis for narcolepsy and OSA. For narcolepsy: must have trial and failure of CNS stimulant (e.g. amphetamine salts, dextroamphetamine, methylphenidate). For shift-work sleep disorder (SWSD): must meet International Classification of Sleep Disorders criteria for SWSD (either primary complaint of excessive sleepiness or insomnia temporarily associated w/ work period that occurs during habitual sleep phase OR polysomnography and Multiple Sleep Latency Test demonstrate loss of normal sleep-wake pattern, no other medical or mental disorders account for symptoms, and symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness such as time zone change syndrome) and must provide chart documentation of shift work schedule showing 5 or more night shifts per month (defined as at least 4 hours of shift occurring between 10pm and 8am). For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	SWSD: 180 days. Narcolepsy, OSA: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	MOLINDONE
Drug Names	MOLINDONE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have a trial and failure or an inadequate response or intolerance to 2 generic antipsychotics (e.g., haloperidol, fluphenazine, chlorpromazine, perphenazine, aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	MULTIPLE SCLEROSIS
Drug Names	BETASERON, COPAXONE, FINGOLIMOD HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For reauth, documentation from provider showing disease has improved or stabilized while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Neurologist or gastroenterologist
Coverage Duration	Initial: 180 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	MYALEPT
Drug Names	MYALEPT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	HIV-related lipodystrophy
Required Medical Information	Diagnosis. Must have chart documentation of a clinical work-up to rule out other diagnoses and clinical rationale for the diagnosis and exclusion of other diagnoses. Must have severe insulin resistance resulting in diabetes mellitus (a hemoglobin A1c of at least 7% or fasting plasma glucose of at least 126mg/dL) with chart documentation showing a trial of diabetic pharmacotherapy (such as with an insulin product) that did not allow the member to achieve adequate glucose control AND/OR must have severe hypertriglyceridemia (triglyceride level of at least 500mg/dL) with chart documentation of a trial of lipid-lowering pharmacotherapy (such as a fibrate, omega-3 fatty acid, or statin) that did not allow the member to achieve adequate triglyceride control. For reauth: must have documentation from prescriber indicating benefit with metreleptin treatment (as evidenced by decrease in hemoglobin A1c, fasting plasma glucose, and/or triglyceride levels from baseline).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Endocrinologist
Coverage Duration	Initial: 180 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	NAYZILAM
Drug Names	NAYZILAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	NITISINONE
Drug Names	NITISINONE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of Hereditary Tyrosinemia Type 1. Laboratory test of baseline succinylacetone (SA) level, liver evaluation, and ophthalmologic testing. For reauth: must have documentation from prescriber indicating improvement in condition, monitoring for hematologic and hepatic side effects, and laboratory test demonstrating progressive SA suppression.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a gastroenterologist, hematologist, nephrologist, or physician who specializes in the treatment of inherited metabolic disorders
Coverage Duration	Initial: 180 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	NUCALA
Drug Names	NUCALA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Pending CMS Review
Age Restrictions	Severe persistent asthma: Age 6 years or older, Eosinophilic granulomatosis with polyangiitis or COPD: Age 18 years or older
Prescriber Restrictions	Severe persistent asthma, COPD: By or in consultation with an allergist, an immunologist, or a pulmonologist, Eosinophilic granulomatosis with polyangiitis: By or in consultation with an allergist, immunologist, pulmonologist, rheumatologist, or hematologist
Coverage Duration	Initial: 180 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	NUEDEXTA
Drug Names	NUEDEXTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Members on quinidine, quinine, mefloquine, MAOIs in the last 14 days, drugs that prolong the QT interval and are metabolized by CYP2D6. History of hypersensitivity to quinidine, quinine, mefloquine, or dextromethorphan. Diagnosis of prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, heart failure, complete AV (atrioventricular) block without an implanted pacemaker, or high risk of complete AV block
Required Medical Information	Diagnosis of pseudobulbar affect (PBA) supported by chart documentation of the following: involuntary outbursts of laughing and/or crying that are incongruous or disproportionate to the patient's emotional state AND documentation of a clinical work-up, including clinical rationale for the PBA diagnosis and exclusion of other possible conditions that could result in emotional lability (e.g. depression, bipolar disorder, schizophrenia, epilepsy). Must have underlying neurological disorder such as amyotrophic lateral sclerosis, multiple sclerosis, Alzheimer's and related diseases, Stroke, Traumatic Brain Injury, or Parkinsonian Syndrome. For reauth: must have documentation from prescriber indicating decrease in number of laughing and/or crying episodes as a result of therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a neurologist
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	NUPLAZID
Drug Names	NUPLAZID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must provide chart documentation of clinical work-up to rule out other diagnoses. Clinical rationale for diagnosis and exclusion of other diagnoses must be provided. Must have tried to discontinue or reduce the dose of any medication(s) that may cause or contribute to hallucinations and delusions (i.e. dopamine agonists, amantadine, monoamine oxidase B inhibitors, anticholinergics) or provide clinical rationale indicating why dose reduction or discontinuation of applicable medications would not be appropriate.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a psychiatrist or neurologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	OFEV AND PIRFENIDONE
Drug Names	OFEV, PIRFENIDONE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For diagnosis of idiopathic pulmonary fibrosis: must have definitive diagnosis of idiopathic pulmonary fibrosis confirmed by either high-resolution computed tomography (HRCT) or surgical lung biopsy, must have all other diagnoses ruled out (e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity), and must submit documentation of baseline liver function testing, including alanine aminotransferase (ALT), aspartate aminotransferase (AST), and bilirubin. For reauth: must have documentation from prescriber indicating that member still is a candidate for treatment and showing that liver function tests (including ALT, AST, and bilirubin) are being monitored regularly.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Pulmonologist
Coverage Duration	Initial: 90 days. Reauth: 180 days.
Other Criteria	Not Applicable

Prior Authorization Group	OJEMDA
Drug Names	OJEMDA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart or lab documentation confirming BRAF fusion or rearrangement, or BRAFV600 mutation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	OMNIPOD
Drug Names	OMNIPOD 5 DEXCOM G7G6 INT, OMNIPOD 5 DEXCOM G7G6 POD, OMNIPOD CLASSIC PDM START, OMNIPOD CLASSIC PODS (GEN, OMNIPOD DASH INTRO KIT (G, OMNIPOD DASH PODS (GEN 4)
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of Type 1 diabetes or pancreatogenous diabetes. Diagnosis of Type 2 diabetes - must be receiving 3 or more insulin injections daily, must have one of the following: HbA1c above 7%, history of recurring hypoglycemia, wide fluctuations in preprandial glucose, dawn phenomenon with fasting blood glucose exceeding 200 mg/dl, history of severe glycemic events.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Endocrinologist or diabetologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	OPIPZA
Drug Names	OPIPZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have trial of generic aripiprazole (tablet, solution, or oral dispersible tablet) or clinical rationale to not being able to use generic formulations. For Major Depressive Disorder without psychosis, must have adequate trial and failure or inadequate response, duration of at least 4 weeks, or intolerance to monotherapy with 1 different antidepressant therapy (e.g., SSRIs or SNRIs) and must be on concomitant therapy with an SSRI or SNRI as adjunctive treatment (which can include medication from monotherapy trial above).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ORAL BUDESONIDE
Drug Names	BUDESONIDE, BUDESONIDE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ORAL ONCOLOGY
Drug Names	ABIRATERONE ACETATE, ABIRTEGA, AKEEGA, AUGTYRO, AVMAPKI FAKZYNJA CO-PACK, BOSULIF, CAPRELSA, COMETRIQ, DANZITEN, DASATINIB, DAURISMO, ERIVEDGE, ERLEADA, EULEXIN, EVEROLIMUS, FRUZAQLA, GLEOSTINE, GOMEKLI, IBRANCE, IBTROZI, ICLUSIG, IMATINIB MESYLATE, IMKELDI, INLYTA, INQOVI, ITOVEBI, IWILFIN, JAYPIRCA, KOSELUGO, KRAZATI, LAZCLUZE, LENALIDOMIDE, 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, LEUKERAN, LORBRENA, LYNPARZA, LYTGOBI, NERLYNX, NILOTINIB HYDROCHLORIDE, NINLARO, NUBEQA, ODOMZO, OGSIVEO, OJJAARA, ONUREG, ORGOVYX, ORSERDU, PAZOPANIB HYDROCHLORIDE, PEMAZYRE, PIQRAY 200MG DAILY DOSE, PIQRAY 250MG DAILY DOSE, PIQRAY 300MG DAILY DOSE, REVUFORJ, REZLIDHIA, ROMVIMZA, ROZLYTREK, RUBRACA, SCEMBLIX, SORAFENIB TOSYLATE, SPRYCEL, STIVARGA, SUNITINIB MALATE, TABLOID, TALZENNA, TASIGNA, TAZVERIK, TEPMETKO, THALOMID, TIBSOVO, TRUQAP, TUKYSA, TURALIO, VANFLYTA, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VIZIMPRO, VORANIGO, WELIREG, XOSPATA, XPOVIO, XPOVIO 60 MG TWICE WEEKLY, XPOVIO 80 MG TWICE WEEKLY, XTANDI, ZEJULA, ZOLINZA, ZYDELIG
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist, hematologist, or neurologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ORKAMBI
Drug Names	ORKAMBI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Documentation of lab result confirming the following mutation in CFTR gene: F508del. Baseline percent of predicted FEV1. For reauth: must have chart documentation from prescriber showing member benefit from treatment, clinical rationale to support continuation of therapy, and current percent predicted FEV1.
Age Restrictions	Age 1 year or older
Prescriber Restrictions	Pulmonologist or cystic fibrosis specialist
Coverage Duration	Initial: 180 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	OTEZLA
Drug Names	OTEZLA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	For plaque psoriasis: min BSA of at least 2% (not req if on palms, soles, head/neck, genitalia) and trial of 1 topical treatment or phototx or photochemotx with inadeq response or sig. side effects/toxicity unless contraindicated. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	OTREXUP AND RASUVO
Drug Names	OTREXUP, RASUVO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have a trial of oral methotrexate or generically-available subcutaneous methotrexate with an inadequate response OR have had a significant side effect/toxicity. For Otrexup requests must have a trial of Rasuvo with an inadequate response OR have had a significant side effect/toxicity. For reauth: must have documentation from the prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	RA, polyarticular JIA: rheumatologist. Psoriasis: dermatologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	PALIPERIDONE
Drug Names	PALIPERIDONE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of schizophrenia or schizoaffective disorder. Must have trial and failure of 2 oral atypical antipsychotics.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	PANRETIN
Drug Names	PANRETIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	By or in consultation with a dermatologist, oncologist, or HIV specialist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	PEGFILGRASTIM
Drug Names	FULPHILA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must be receiving chemo regimen with dosing frequency of once every 2 wks or greater. For primary prophylaxis of febrile neutropenia (FN): must be receiving either myelosuppressive chemo regimen with greater than 20% risk of FN (per ASCO or NCCN guidelines) or non-myelosuppressive chemo regimen (less than or equal to 20% risk of FN) and considered to be at high risk for chemo-induced FN or infection with at least one risk factor (age 65 years or older, poor performance status, previous episode of FN, extensive prior treatment including large radiation ports, previous chemotherapy or radiation therapy, pre-existing neutropenia, cytopenia due to bone marrow involvement by tumor, poor nutritional status, presence of open wounds or active infection, recent surgery, advanced cancer, liver dysfunction such as elevated bilirubin, or other serious comorbidities). For secondary prophylaxis of FN: must have experienced a neutropenic complication from prior chemo cycle for which primary prophylaxis was not received and in which reduced dose may compromise disease-free or overall survival or treatment outcome. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	90 days
Other Criteria	Not Applicable

Prior Authorization Group	PENICILLAMINE
Drug Names	PENICILLAMINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have baseline (within 6 months) urinalysis, complete blood cell count, platelet count, and hemoglobin. For Wilson's disease, must have chart documentation of how diagnosis was confirmed including at least one of the following: hepatic parenchymal copper content greater than or equal to 250 micrograms per gram dry weight, presence of Kayser-Fleischer Ring in cornea, serum ceruloplasmin level less than 50mg/L, basal 24-hour urinary excretion of copper greater than 100 micrograms (1.6 millimoles), or genetic testing indicating mutation in ATP7B gene. For Cystinuria: must have chart documentation of how diagnosis was confirmed. For Rheumatoid Arthritis: must have severely active disease, must have a trial of methotrexate with inadequate response or significant side effects or toxicity or have a contraindication, and must have a trial of leflunomide, hydroxychloroquine, minocycline, or sulfasalazine with inadequate response or significant side effects or toxicity or have a contraindication. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Wilson's disease: by or in consultation with gastroenterologist or physician who specializes in the treatment of inherited metabolic disorders. Cystinuria: by or in consultation with nephrologist or physician who specializes in the treatment of inherited metabolic disorders. RA: rheumatologist
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	PHEOCHROMOCYTOMA
Drug Names	METYROSINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have surgical resection planned, have a contraindication to surgery, or have malignant pheochromocytoma. For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a nephrologist, oncologist, endocrinologist, or endocrine surgeon
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	POMALYST
Drug Names	POMALYST
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For diagnosis of multiple myeloma: must have received at least two prior therapies including lenalidomide and a proteasome inhibitor (example: ixazomib (Ninlaro)).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	POSACONAZOLE
Drug Names	POSACONAZOLE, POSACONAZOLE DR
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Members on the following medications: terfenadine, pimozide, quinidine, sirolimus.
Required Medical Information	Diagnosis. For prophylaxis of Aspergillus and Candida infections (tablet, or suspension): must be severely immunocompromised. For treatment of oropharyngeal candidiasis (suspension): must have trial and failure of fluconazole or itraconazole for at least 10 days. For treatment of invasive aspergillosis: no other documentation required. For reauth: must have documentation from prescriber indicating clinical rationale for retreatment.
Age Restrictions	Age 2 years or older
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	Prophy of Aspergill/Candida: 120 dys. Tx of aspergillosis: 90 dys. Oropharyngeal Candida: 30 dys.
Other Criteria	Not Applicable

Prior Authorization Group	PREVYMIS
Drug Names	PREVYMIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	100 days
Other Criteria	Not Applicable

Prior Authorization Group	PROMACTA
Drug Names	ELTROMBOPAG OLAMINE, PROMACTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For ITP: must have platelet count less than 30,000. For thrombocytopenia associated with chronic Hepatitis C: must have platelet count of less than 75,000 and currently be on treatment with or anticipating hepatitis C treatment with interferon product. For aplastic anemia: must have severe disease, must have platelet count less than 30,000, and must either be used in combination with standard immunosuppressive therapy or have previous inadequate response or intolerance to antithymocyte globulin-based immunosuppressive therapy (Atgam, Thymoglobulin). For reauth: must have documentation from prescriber indicating improvement in condition (all dx), improvement in platelet count from baseline (all dx), and hematologic response (aplastic anemia dx: increase in platelet count, increase in Hgb, increase in ANC, reduction in frequency of platelet or RBC transfusions).
Age Restrictions	ITP: age 1 year or older. Severe aplastic anemia: age 2 years or older. Other diagnoses: age 18 years or older.
Prescriber Restrictions	ITP, aplastic anemia: hematologist or oncologist. Hep C: gastroenterologist, hematologist, hepatologist, or infectious disease specialist.
Coverage Duration	180 days
Other Criteria	Not Applicable

Prior Authorization Group	PULMOZYME
Drug Names	PULMOZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of cystic fibrosis. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Pulmonologist
Coverage Duration	365 Days
Other Criteria	BvsD determination will be made prior to clinical criteria being applied.

Prior Authorization Group	PURIXAN
Drug Names	PURIXAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have a trial and failure of mercaptopurine tablets or have chart documentation of the clinical rationale for why the tablet version cannot be used.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a hematologist or an oncologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	QINLOCK
Drug Names	QINLOCK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For diagnosis of advanced gastrointestinal stromal tumor (GIST): must have received prior treatment with 3 or more kinase inhibitors, including imatinib.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	QUETIAPINE
Drug Names	QUETIAPINE FUMARATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	QUETIAPINE ER
Drug Names	QUETIAPINE FUMARATE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For schizophrenia, bipolar disorder: must have previous trial and failure of immediate-release quetiapine. For major depressive disorder: must have adequate trial and failure (duration at least 4 weeks) with 2 different antidepressant therapies (e.g. SSRIs, SNRIs) with inadequate responses or intolerance.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	QUININE
Drug Names	QUININE SULFATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of malaria. For reauth: must have documentation from prescriber indicating continued benefit from therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 Days
Other Criteria	Not Applicable

Prior Authorization Group	RALDESY
Drug Names	RALDESY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have trial of trazodone tablets or clinical rationale to not being able to use tablets.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	REPATHA
Drug Names	REPATHA, REPATHA PUSHTRONEX SYSTEM, REPATHA SURECLICK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	RETEVMO
Drug Names	RETEVMO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Current weight.
Age Restrictions	Thyroid cancer: 2 years of age or older. NSCLC: 18 years of age or older.
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	REXULTI
Drug Names	REXULTI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For Major Depressive Disorder: must have trial and failure or inadequate response or intolerance to aripiprazole and must be on concomitant therapy with an SSRI or SNRI as adjunctive treatment. For Schizophrenia: must have a trial and failure or inadequate response or intolerance to 2 generic oral atypical antipsychotics (e.g. aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	REZUROCK
Drug Names	REZUROCK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Trial and failure, or intolerance of at least two anti-rejection systemic therapies.
Age Restrictions	Age 12 years or older
Prescriber Restrictions	By or in consultation with a transplant specialist or oncologist
Coverage Duration	365 days
Other Criteria	Not applicable

Prior Authorization Group	RINVOQ
Drug Names	RINVOQ, RINVOQ LQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Evidence of infection. Use of another JAK inhibitor or other biologic agent in combination with upadacitinib.
Required Medical Information	Negative TB skin test. For psoriatic arthritis (PsA) or ankylosing spondyltis (AS): must have active disease. For all other dx: must have mod to severely active dx. For RA: trial of methotrexate (MTX) and one TNF blocker with inadeq response (if sig. side effects/toxicity or contraindication (CI) to MTX must have trial of hydroxychloroquine, leflunomide, or sulfasalazine). For psoriatic arthritis (peripheral disease, in patients 18 and older): must have moderately to severely active psoriatic arthritis AND must have trial of 1 NSAID at target anti-inflammatory dose and of 1 conventional systemic therapy (e.g. methotrexate, cyclosporine, leflunomide, sulfasalazine) with inadequate responses or significant side effects/toxicities or have contraindication to these therapies. For psoriatic arthritis (peripheral disease, in patients 17 and younger): must have moderately to severely active psoriatic arthritis AND must have trial of 1 NSAID at target anti-inflammatory dose. For psoriatic arthritis (axial, skin, nail, enthesitis, or dactylitis dominant): must have a trial of 2 NSAIDs at target anti-inflammatory dose with inadeq response or sig. side effects/toxicities unless contraindicated. For atopic dermatitis: trial of 1 systemic drug product (e.g., azathioprine, or cyclosporine) unless CI. For Crohns or UC: trial of 1 conventional therapy incl corticosteroid, 5-ASA agent (UC only), or immunosuppressant AND 1 TNF blocker with inadeq response or sig. side effects/toxicity unless CI. For active non-radiographic axial spondyloarthritis (nr-axSpA): no drug trials required. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	RA, nr-axSpA: rheumatologist. Psoriatic arthritis, atopic dermatitis: rheumatologist, dermatologist. Crohns or UC: gastroenterologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ROFLUMILAST
Drug Names	ROFLUMILAST
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Moderate to severe liver impairment.
Required Medical Information	Diagnosis of GOLD Stage III or IV COPD associated with chronic bronchitis. Documentation of COPD exacerbation within the past year. Must have trial and failure of inhaled long-acting beta-agonist or inhaled long-acting anticholinergic or a contraindication to these agents. Must have trial and failure of inhaled glucocorticosteroid or a contraindication to these agents. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	RUFINAMIDE
Drug Names	RUFINAMIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of Lennox-Gastaut Syndrome. Must have had an inadequate response or intolerance to 2 generic antiepileptic drugs (e.g. lamotrigine, topiramate, felbamate) and be using rufinamide as adjunctive therapy to other antiepileptic drugs (which can include medication from trial above).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a neurologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	RYDAPT
Drug Names	RYDAPT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For acute myeloid leukemia: must have chart documentation of lab result confirming FLT3 mutation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist, hematologist, or allergist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	SAPROPTERIN
Drug Names	JAVYGTOR, SAPROPTERIN DIHYDROCHLORI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Baseline serum phenylalanine level. For reauth: must have documentation from prescriber indicating response to therapy, follow-up serum phenylalanine level.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	Initial: 60 days. Reauth: 365 days.
Other Criteria	Continuation/Discontinuation criteria: lab reassessment will be conducted after an initial one month trial. Patients on the 10mg/kg/day dose whose blood phenylalanine levels have not decreased from baseline after 1 month of treatment should increase to 20mg/kg/day. These patients will be approved for another one month trial at the higher dose. Patients on the 20mg/kg/day dose whose blood phenylalanine levels have not decreased from baseline after 1 month are considered non-responders, and treatment with sapropterin should be discontinued in these patients.

Prior Authorization Group	SAVELLA
Drug Names	SAVELLA, SAVELLA TITRATION PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart documentation showing history of widespread pain involving the extremities for 3 months and localized areas of tenderness. Must have chart documentation or claims history showing a trial of gabapentin at a dose of at least 1200mg/day with inadequate response or significant side effects/toxicity despite slow dose titration or have a contraindication to this therapy. Must have chart documentation or claims history showing a trial of a tricyclic antidepressant (e.g. amitriptyline) or muscle relaxant (e.g. cyclobenzaprine) with inadequate response or significant side effects/toxicity or have a contraindication to these therapies. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	SECUADO
Drug Names	SECUADO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have tried and failed 2 atypical antipsychotics.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	SIGNIFOR
Drug Names	SIGNIFOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart documentation of confirmed pituitary source of Cushing's syndrome. Must previously have had pituitary surgery (e.g. transsphenoidal surgery) that was not curative unless not a candidate for surgery. Must have baseline 24-hour urinary free cortisol level. Must have recent (within 6 months) baseline assessments of fasting plasma glucose, liver function tests, electrocardiogram, gallbladder ultrasound, pituitary hormones (e.g. TSH, free T4, growth hormone, IGF-1), and hemoglobin A1C. For reauth: must have documentation from prescriber indicating improvement in condition based on reduction in 24-hour urinary free cortisol level from baseline level as well as signs and symptoms of improvement in the disease (e.g. blood pressure, lipids, weight) and must have documentation that hemoglobin A1C, fasting plasma glucose, liver function tests, gallbladder ultrasound, pituitary hormones, and electrocardiogram have all been reassessed within 3 months of starting pasireotide and at regular intervals thereafter.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	By or in consultation with an endocrinologist
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	SILDENAFIL
Drug Names	SILDENAFIL CITRATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Current use of nitrate product
Required Medical Information	Diagnosis of PAH (WHO Group I) confirmed diagnosis by right heart catheterization. Must have chart documentation of right heart catheterization that indicates the following hemodynamic values: mean pulmonary arterial pressure greater than or equal to 25 mmHg, pulmonary capillary wedge pressure OR left atrial pressure OR left ventricular end-diastolic pressure less than or equal to 15 mmHg, pulmonary vascular resistance greater than 3 Wood units. Must have WHO Functional Class II-IV symptoms. For sildenafil suspension: must have chart documentation of the clinical rationale for why sildenafil tablet cannot be used. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Cardiologist or pulmonologist. Combination therapy with two or more PAH agents must be prescribed by or in consultation with a pulmonary hypertension specialist.
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	SIROLIMUS
Drug Names	SIROLIMUS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Must have diagnosis of lymphangioleiomyomatosis or prophylaxis of organ rejection. For prophylaxis of organ rejection, must have undergone solid organ transplant and must have at least one of the following: renal dysfunction, coronary allograft vasculopathy following heart transplant, OR trial and failure (defined as intolerance to regimen or inability of regimen to prevent rejection at appropriate therapeutic dosing) of anti-rejection regimen containing at least 2 drugs (including cyclosporine, tacrolimus, azathioprine, mycophenolate mofetil, mycophenolate sodium).
Age Restrictions	Prophylaxis of organ rejection: age 13 years or older. Lymphangioleiomyomatosis: age 18 years or older.
Prescriber Restrictions	Prophylaxis of organ rejection: by or in consultation with a transplant specialist. Lymphangioleiomyomatosis: pulmonologist, hematologist, or oncologist.
Coverage Duration	365 Days
Other Criteria	B vs. D determination will be made prior to clinical criteria being applied.

Prior Authorization Group	SIRTURO
Drug Names	SIRTURO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have previously had inadequate response to at least one first-line TB regimen containing isoniazid and rifampin OR have chart documentation of susceptibility testing of Mycobacterium tuberculosis isolates demonstrating resistance to isoniazid and rifampin. Must be using bedaquiline in combination with at least three other drugs active against pulmonary TB. For reauth: must have documentation from prescriber indicating member's initial response to therapy and clinical rationale for continuation of treatment or for re-treatment AND must have chart documentation of susceptibility testing of Mycobacterium tuberculosis isolates demonstrating continued susceptibility to bedaquiline.
Age Restrictions	Age 5 years or older
Prescriber Restrictions	By or in consultation with an infectious disease specialist or pulmonologist
Coverage Duration	180 days
Other Criteria	Not Applicable

Prior Authorization Group	SKELETAL MUSCLE RELAXANTS
Drug Names	CARISOPRODOL, CHLORZOXAZONE, CYCLOBENZAPRINE HYDROCHLO, METHOCARBAMOL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have attestation from prescriber assessing the risks and benefits of therapy and desire to prescribe a muscle relaxant.
Age Restrictions	Age 65 years or older: criteria apply. Age less than 65 years: criteria do not apply.
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	SKYRIZI
Drug Names	SKYRIZI, SKYRIZI PEN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Evidence of infection. Use of another biologic agent in combination with risankizumab.
Required Medical Information	Negative TB skin test. For psoriatic arthritis (PsA): must have active disease. For plaque psoriasis (PS): must have moderate to severe active dx. For psoriatic arthritis (peripheral disease): must have moderately to severely active psoriatic arthritis AND must have trial of 1 NSAID at target anti-inflammatory dose and of 1 conventional systemic therapy (e.g. methotrexate, cyclosporine, leflunomide, sulfasalazine) with inadequate responses or significant side effects/toxicities or have contraindication to these therapies. For psoriatic arthritis (axial, skin, nail, enthesitis, or dactylitis dominant): must have a trial of 2 NSAIDs at target anti-inflammatory dose with inadeq response or sig. side effects/toxicities unless contraindicated. For plaque psoriasis: must have chronic moderate to severe plaque psoriasis, must have minimum BSA involvement of at least 5% (not required if plaque psoriasis on palms, soles, head/neck, or genitalia), must have trial of 1 topical treatment or phototherapy or photochemotherapy with inadequate response or significant side effects/toxicity or have a contraindication, and must have trial of 1 conventional systemic therapy (e.g. methotrexate, acitretin, cyclosporine) with inadequate response or significant side effects/toxicity or have a contraindication. For Crohns: trial of 1 conventional therapy including corticosteroid or immunosuppressant with inadeq response or sig. side effects/toxicity unless contraindicated. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Age 18 years or older.
Prescriber Restrictions	Psoriatic arthritis: rheumatologist, dermatologist. Plaque psoriasis: dermatologist. Crohns disease: gastroenterologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	SODIUM OXYBATE
Drug Names	SODIUM OXYBATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For cataplexy associated with narcolepsy: must have chart documentation and sleep study to confirm diagnosis. For excessive daytime sleepiness associated with narcolepsy: must have polysomnographic evaluation and chart documentation supporting clinical history of narcolepsy AND must have a trial and failure of 2 central nervous stimulants (e.g. modafinil, armodafinil, amphetamine salts, dextroamphetamine, methylphenidate). For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Age 7 years or older
Prescriber Restrictions	Board-certified sleep specialist, pulmonologist, or neurologist
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	SODIUM PHENYLBUTYRATE
Drug Names	SODIUM PHENYLBUTYRATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart documentation describing how diagnosis was confirmed (e.g. genetic testing results, enzyme assays, ammonia levels, progress notes, etc.). For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a hematologist, nephrologist, or physician who specializes in the treatment of inherited metabolic disorders.
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	SOMAVERT
Drug Names	SOMAVERT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of acromegaly. Must have following baseline labs: elevated serum IGF-1 level for gender/age range (including lab reference range) and elevated growth hormone level defined as GH at least 1ng/mL during oral glucose tolerance test. Must have inadequate response to surgery or radiation therapy or documentation that these therapies are inappropriate. Must have inadequate response to 1 medical therapy (e.g. octreotide, lanreotide) or documentation that these therapies are inappropriate. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	By or in consultation with an endocrinologist
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	SPRITAM
Drug Names	SPRITAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have had an inadequate response or intolerance to generic levetiracetam and one other generic antiepileptic drug (such as carbamazepine, oxcarbazepine, or phenytoin).
Age Restrictions	Age 4 years or older
Prescriber Restrictions	By or in consultation with a neurologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	STELARA
Drug Names	STELARA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Negative TB skin test. For plaque psoriasis (PS): must have chronic moderate to severe dx, must have minimum BSA of at least 5% (not required if on palms, soles, head/neck, genitalia), and must have had an inadequate response, intolerance, or contraindication to 2 of the following: Enbrel, Humira, Otezla, or Skyrizi. For Crohn's disease: must have moderately to severely active disease, and must have had an inadequate response, intolerance, or contraindication to both Humira and Skyrizi. For psoriatic arthritis (in patients 18 and older): must have had an inadequate response, intolerance, or contraindication to 2 of the following: Enbrel, Humira, Otezla, Rinvoq, Skyrizi, or Xeljanz/Xeljanz XR. For psoriatic arthritis (in patients 6 to 17 years of age): must have had an inadequate response, intolerance, or contraindication to Rinvoq. For ulcerative colitis: must have had an inadequate response, intolerance, or contraindication to 2 of the following: Humira, Rinvoq, or Xeljanz/Xeljanz XR. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Plaque psoriasis, psoriatic arthritis: 6 years or older. Crohn's or UC: 18 years or older.
Prescriber Restrictions	Psoriatic arthritis: rheumatologist, dermatologist. Plaque psoriasis: dermatologist. Crohn's or UC: gastroenterologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	SUCRAID
Drug Names	SUCRAID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For congenital sucrase-isomaltase deficiency: must have low sucrase activity on duodenal biopsy with other disaccharidases normal on same duodenal biopsy OR must have stool pH less than 6, increase in breath hydrogen of greater than 10ppm when challenged with sucrose after fasting, and negative lactose breath test. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Age 5 months or older
Prescriber Restrictions	Gastroenterologist, endocrinologist, or metabolic specialist
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	SYMPAZAN
Drug Names	SYMPAZAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of Lennox-Gastaut syndrome. Must have had an inadequate response or intolerance to generic clobazam tablets and 1 other generic antiepileptic drug (e.g. lamotrigine, topiramate, felbamate) and be using as adjunctive therapy to other anti-epileptic drugs.
Age Restrictions	Age 2 years or older
Prescriber Restrictions	By or in consultation with a neurologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	TABRECTA
Drug Names	TABRECTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart documentation of lab result confirming MET exon 14 mutation.
Age Restrictions	Age 18 and older
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	TADALAFIL
Drug Names	ALYQ, TADALAFIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Current use of nitrate product
Required Medical Information	Diagnosis of PAH (WHO Group I) confirmed diagnosis by right heart catheterization. Must have chart documentation of right heart catheterization that indicates the following hemodynamic values: mean pulmonary arterial pressure greater than or equal to 25 mmHg, pulmonary capillary wedge pressure OR left atrial pressure OR left ventricular end-diastolic pressure less than or equal to 15 mmHg, pulmonary vascular resistance greater than 3 Wood units. Must have WHO Functional Class II-IV symptoms. Must have inadequate response or intolerance to sildenafil (Revatio). For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Cardiologist or pulmonologist. Combination therapy with two or more PAH agents must be prescribed by or in consultation with a pulmonary hypertension specialist.
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	TADALAFIL - BPH
Drug Names	TADALAFIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Use for treatment of erectile dysfunction without comorbid diagnosis of benign prostatic hyperplasia.
Required Medical Information	Diagnosis. For benign prostatic hyperplasia (BPH): must have a trial and failure, intolerance, or contraindication to 1 alpha1 receptor antagonist (e.g., alfuzosin, doxazosin, prazosin, tamsulosin, or terazosin) AND a 5-alpha reductase inhibitor (e.g., finasteride or dutasteride).
Age Restrictions	Age 18 years or older
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	TAFINLAR
Drug Names	TAFINLAR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For unresectable, metastatic, or completely resected melanoma: must have chart documentation of lab result confirming BRAFV600E or BRAFV600K mutation. For metastatic non-small cell lung cancer or locally advanced or metastatic anaplastic thyroid cancer: must have chart documentation of lab result confirming BRAFV600E mutation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	TAGRISSO
Drug Names	TAGRISSO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart documentation of lab result confirming epidermal growth factor receptor (EGFR) T790M mutation, exon 19 deletions, or exon 21 L858R mutations.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	TAKHZYRO
Drug Names	TAKHZYRO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of HAE and confirmatory laboratory values on 2 separate instances (copy of laboratory reports required, must include reference ranges). For Type I: low C4 complement level in mg/dL, normal C1q complement component level in mg/dL (C1q complement component level not required for patients under age of 18 or patients whose symptoms began before age 18), and either low C1 esterase inhibitor antigenic level in mg/dL or low C1 esterase inhibitor functional level expressed as a percent. For Type II: low C4 complement level in mg/dL, normal C1q complement component level in mg/dL (C1q complement component level not required for patients under age of 18 or patients whose symptoms began before age 18), and low C1 esterase inhibitor functional level expressed as a percent. For Type III: chart documentation of exclusion of other possible diagnoses and/or causes of angioedema. For reauth, must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Age 2 years or older
Prescriber Restrictions	By or under the direction of a HAE specialist (defined as an allergist/immunologist who attests to clinical experience in HAE).
Coverage Duration	365 days
Other Criteria	Must be used as prophylactic therapy for prevention of HAE attacks

Prior Authorization Group	TASIMELTEON
Drug Names	HETLIOZ LQ, TASIMELTEON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must submit chart documentation describing how diagnosis was confirmed (e.g. sleep-wake logs, melatonin secretion abnormalities, progress notes, genetic testing for SMS, etc.). For diagnosis of non-24-hour sleep-wake disorder: patient must be totally blind with no perception of light. For diagnosis of Smith-Magenis Syndrome: no other clinical information required. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By a neurologist or physician who specializes in sleep medicine
Coverage Duration	Initial: 180 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	TAVNEOS
Drug Names	TAVNEOS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have a trial of glucocorticoids or had an inadequate response or intolerance, side effects, toxicity, or have a contraindication to therapy. Must be used in combination with standard therapy (glucocorticoids).
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Rheumatologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	TERIPARATIDE
Drug Names	BONSITY, TERIPARATIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have trial and failure of bisphosphonate therapy or raloxifene unless intolerant or contraindicated. Must have bone mineral density T-score of less than or equal to -2.5 at conventional skeletal sites including the total hip, femoral neck, lumbar spine (post-anterior, not lateral) or radius OR must have history of fracture due to osteoporosis. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 Days
Other Criteria	Not Applicable

Prior Authorization Group	TETRABENAZINE
Drug Names	TETRABENAZINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Actively suicidal. Uncontrolled depression. Currently using a monoamine oxidase inhibitor or reserpine. Hepatic impairment.
Required Medical Information	Diagnosis. Must have confirmed Huntington's disease either by Huntington Disease Mutation analysis (with laboratory result indicating expanded CAG repeat of greater than or equal to 36 in the huntington gene) or a positive family history of Huntington's Disease with autosomal dominant inheritance pattern. Must have clinical signs of Huntington's Disease to include chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia), affective (e.g. depression), cognitive. Must have chart documentation of chorea associated with Huntington's Disease. For doses greater than 50mg/day: must have chart documentation of a trial of 50mg/day dose with inadequate response OR must be CYP2D6 intermediate or extensive metabolizer (as documented through CYP2D6 genotyping results), must provide documentation of slow dose titration with close monitoring of side effects. For reauth: must have documentation from the prescriber indicating improvement in condition and showing monitoring for depression and suicidal ideation. For reauth for doses greater than 50mg/day: must have chart documentation from prescriber showing inadequate efficacy of lower doses and slow titration of dose with close monitoring of side effects.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Neurologist
Coverage Duration	365 days
Other Criteria	Maximum dose approved is 100mg/day.

Prior Authorization Group	TIOPRONIN
Drug Names	TIOPRONIN, TIOPRONIN DR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have severe homozygous cystinuria with urinary cystine level greater than 500mg/day. Must have chart documentation of how diagnosis was confirmed. Must have baseline (within 6 months) urinalysis, complete blood cell count, platelet count, hemoglobin, and liver function tests. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a urologist, nephrologist, or physician who specializes in the treatment of inherited metabolic disorders
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	TOPICAL LIDOCAINE
Drug Names	LIDOCAINE, LIDOCAINE/PRILOCAINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	If being used as part of a compounded product, all active ingredients in the compounded product must be FDA approved for topical use.

Prior Authorization Group	TOPICAL TACROLIMUS AND PIMECROLIMUS
Drug Names	PIMECROLIMUS, TACROLIMUS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Weakened or compromised immune system
Required Medical Information	Diagnosis. For topical tacrolimus: must have trial and failure of moderate to high potency topical corticosteroid or have a contraindication to this therapy (such as dermatitis on face, genitalia). For topical pimecrolimus: must have trial and failure of moderate to high potency topical corticosteroid or have a contraindication to this therapy (such as dermatitis on face, genitalia) AND must have trial and failure of topical tacrolimus with inadequate response or significant side effect/toxicity or have a contraindication to this therapy. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Pimecrolimus, tacrolimus 0.03%: age 2 years or older. Tacrolimus 0.1%: age 16 years or older.
Prescriber Restrictions	No Prescriber Restrictions.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	TOREMIFENE
Drug Names	TOREMIFENE CITRATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have previous inadequate response or intolerance to tamoxifen.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	TRIENTINE
Drug Names	TRIENTINE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart documentation of how diagnosis was confirmed including at least one of the following: hepatic parenchymal copper content greater than or equal to 250 micrograms per gram dry weight, presence of Kayser-Fleischer Ring in cornea, serum ceruloplasmin level less than 200mg/L, basal 24-hour urinary excretion of copper greater than 100 micrograms (1.6 millimoles), or genetic testing indicating mutation in ATP7B gene. Must have trial of penicillamine (Depen) with an inadequate response or significant side effects/toxicity or must have a contraindication to this therapy. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	By or in consultation with a gastroenterologist, ophthalmologist, or physician who specializes in the treatment of inherited metabolic disorders
Coverage Duration	Initial: 90 days. Reauth 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	VALCHLOR
Drug Names	VALCHLOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist, hematologist, or dermatologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	VECAMYL
Drug Names	VECAMYL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Mild, moderate, and/or labile hypertension. Coronary insufficiency or recent myocardial infarction. Renal insufficiency manifested by rising or elevated BUN level. Uremia. Concurrent use of antibiotics and sulfonamides. Glaucoma. Organic pyloric stenosis. Hypersensitivity to mecamylamine.
Required Medical Information	Diagnosis of moderately severe to severe essential hypertension or uncomplicated malignant hypertension. Must have documented trials of 2 formulary antihypertensive medications from different classes (such as an angiotensin receptor blocker [i.e. irbesartan] and a thiazide diuretic [i.e. hydrochlorothiazide]) with therapeutic failure. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Cardiologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	VELTASSA
Drug Names	VELTASSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have documentation of elevated serum potassium. Must have tried modification of medication regimen to reduce the risk of hyperkalemia if clinically appropriate. Must have trial of, contraindication to, or intolerance to sodium polystyrene sulfonate. For reauth: must have documentation of persistent hyperkalemia and prior reduction in serum potassium levels with Veltassa (patiromer).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	VEOZAH
Drug Names	VEOZAH
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Prior trial of at least 2 agents (e.g., estradiol, combined estrogen-progestin, Duavee, paroxetine) for vasomotor symptoms of menopause or inadequate response, intolerance, side effects, toxicity, or have a contraindication to other therapies.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	VERQUVO
Drug Names	VERQUVO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have baseline negative pregnancy test prior to initiation of vericiguat (if a female of childbearing potential). For new starts, must have documentation of ejection fraction less than 45% and either recent hospitalization for heart failure or need for outpatient intravenous diuretics. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Cardiologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	VERSACLOZ
Drug Names	VERSACLOZ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have a trial and failure of both clozapine tablet AND clozapine orally-disintegrating tablet or have chart documentation of the clinical rationale for why the tablet and orally-disintegrating tablet versions cannot be used.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No prescriber restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	VIGABATRIN
Drug Names	VIGABATRIN, VIGADRONE, VIGAFYDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must undergo vision testing prior to beginning treatment. For Refractory Complex Partial Seizures: must have inadequate response to 2 anticonvulsant medications (at least 1 medication must be phenytoin or carbamazepine unless intolerant or contraindicated). Must be using in combination with at least 1 other anticonvulsant medication.
Age Restrictions	Seizure: age 2 years or older. Infantile spasms: age 1 month to 2 years.
Prescriber Restrictions	Neurologist or pediatric neurologist.
Coverage Duration	365 days
Other Criteria	For infantile spasms will not be extended beyond the age of 2 years.

Prior Authorization Group	VILAZODONE AND VORTIOXETINE
Drug Names	TRINTELLIX, VILAZODONE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have trial and failure or intolerance to 1 generic antidepressants from either SSRI or SNRI classes.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	VITRAKVI
Drug Names	VITRAKVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Documentation of lab result confirming neurotrophic receptor tyrosine kinase [NTRK] gene fusion.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	VONJO
Drug Names	VONJO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of intermediate or high-risk myelofibrosis (includes primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis). Documentation of baseline platelet count below 50 x 10^9/L prior to initiation of Vonjo.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Hematologist or oncologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	VORICONAZOLE INJECTION
Drug Names	VORICONAZOLE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

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	Diagnosis of chronic Hep C. Doc of prior treatment (tx) for Hep C (if applicable) so that criteria can be applied consistent with current AASLD-IDSA guidance. Chart doc of lab genotype (GT) result, detectable baseline HCV RNA level (incl. assay date, ref. range), test indicating presence or absence of cirrhosis (e.g. F4 score on liver biopsy from within past 3 years, MRI, ultrasound, CT scan).
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Infectious disease physician, gastroenterologist, hepatologist, HIV specialist, or transplant physician
Coverage Duration	12 weeks
Other Criteria	Regimens/requirements based on AASLD/IDSA Hep C Tx Guidelines found at https://www.hcvguidelines.org/.

Prior Authorization Group	VOWST
Drug Names	VOWST
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have a trial of fidaxomicin and vancomycin or had an inadequate response or intolerance, side effects, toxicity, or have a contraindication to these therapies.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Gastroenterologist or infectious disease physician
Coverage Duration	3 doses (4 capsules per dose) per 365 days
Other Criteria	Not Applicable

Prior Authorization Group	VRAYLAR
Drug Names	VRAYLAR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have a trial and failure or an inadequate response or intolerance to 2 generic antipsychotics (e.g., haloperidol, fluphenazine, chlorpromazine, perphenazine, aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone).
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	XALKORI
Drug Names	XALKORI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart documentation of lab result confirming ALK or ROS1 mutation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	XCOPRI
Drug Names	XCOPRI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Familial short QT syndrome.
Required Medical Information	Diagnosis. Must have had an inadequate response or intolerance to 2 formulary generic antiepileptic drugs (e.g. lamotrigine, topiramate, felbamate)
Age Restrictions	Age 18 years or older
Prescriber Restrictions	By or in consultation with a neurologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	XDEMVY
Drug Names	XDEMVY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Chart documentation confirming diagnosis of Demodex blepharitis.
Age Restrictions	No age restriction
Prescriber Restrictions	Ophthalmologist
Coverage Duration	6 weeks
Other Criteria	Not Applicable

Prior Authorization Group	XELJANZ
Drug Names	XELJANZ, XELJANZ XR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Evidence of infection. Use of biologic disease-modifying antirheumatic drug or potent immunosuppressive agent (e.g. azathioprine, cyclosporine) in combination with tofacitinib. Severe hepatic impairment.
Required Medical Information	Diagnosis. Must have negative tuberculosis skin test. For moderately to severely active RA: Must have trial and failure of methotrexate with inadequate response (if significant side effects, toxicity, or contraindication to methotrexate, must have trial of hydroxychloroquine, leflunomide, or sulfasalazine). Must have lymphocyte count greater than or equal to 500 cells per cubic mm, ANC greater than or equal to 1000 cells per cubic mm, and Hgb level greater than or equal to 9g/dL. For psoriatic arthritis (peripheral disease): must have moderately to severely active psoriatic arthritis AND must have trial of 1 NSAID at target anti-inflammatory dose and of 1 conventional systemic therapy (e.g. methotrexate, cyclosporine, leflunomide, sulfasalazine) with inadequate responses or significant side effects/toxicities or have contraindication to these therapies. For psoriatic arthritis (axial, skin, nail, enthesitis, or dactylitis dominant): must have a trial of 2 NSAIDs at target anti-inflammatory dose with inadeq response or sig. side effects/toxicities unless contraindicated. For reauth: must have documentation from the prescriber indicating stabilization or improvement in condition AND recent lymphocyte count, ANC, Hgb, lipid levels, liver function tests. Lymphocyte count, ANC, Hgb, lipid levels, liver function tests must be completed within 3 months of therapy initiation and at regular intervals thereafter.
Age Restrictions	Age 2 years or older
Prescriber Restrictions	RA: Rheumatologist, Psoriatic Arthritis: Rheumatologist or dermatologist, Ulcerative colitis: gastroenterologist.
Coverage Duration	Initial: 120 days. Reauth: 365 days.
Other Criteria	Not applicable

Prior Authorization Group	XERMELO
Drug Names	XERMELO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For diarrhea: must be associated with carcinoid syndrome. Must have had a previous trial of a somatostatin analog (e.g., octreotide) with failure or inadequate control of symptoms. Must be used in combination with a somatostatin analog. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Oncologist, hematologist, endocrinologist, gastroenterologist or palliative care specialist.
Coverage Duration	Initial: 90 days. Reauth: 365 days.
Other Criteria	Not Applicable

Prior Authorization Group	XGEVA
Drug Names	XGEVA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Concurrent treatment with denosumab (Prolia).
Required Medical Information	Diagnosis of prevention of skeletal-related events in patients with multiple myeloma or bone metastases from solid tumors. For giant cell tumor, must have disease that is unresectable or where surgical resection is likely to result in severe morbidity and member must be skeletally mature if less than 18 years of age. For hypercalcemia of malignancy: must have a trial and failure of IV bisphosphonate therapy (i.e. zoledronic acid 4mg/5mL or 4mg/100mL), with failure defined as an albumin-corrected calcium greater than 12.5mg/dL (3.1 mmol/L) despite recent treatment with an IV bisphosphonate.
Age Restrictions	Prevention of skeletal events, hypercalcemia of malignancy: age 18 years or older. Giant Cell Tumor: age 13 years or older.
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 Days
Other Criteria	Not Applicable

Prior Authorization Group	XIFAXAN
Drug Names	XIFAXAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For hepatic encephalopathy: must have trial and failure of lactulose. For diarrhea-predominant irritable bowel syndrome (IBS-D): must have chart documentation of how the diagnosis was confirmed and a trial and failure of loperamide AND an antispasmodic (e.g. dicyclomine) with an inadequate response or significant side effect/toxicity or have a contraindication to these therapies. Reauth for hepatic encephalopathy: must have chart documentation from prescriber indicating improvement in condition. Reauth for IBS-D: must have documentation from prescriber indicating recurrence of IBS-D symptoms after a successful treatment with rifaximin.
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Hepatic encephalopathy: 365 Days. IBS-D initial: 14 days. IBS-D reauth: 14 days.
Other Criteria	Criteria only applies to rifaximin 550mg. Criteria does not apply to rifaximin 200mg. For IBS-D: patients who experience a recurrence of symptoms can be retreated up to two times with the same dosage regimen.

Prior Authorization Group	XOLAIR
Drug Names	XOLAIR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For moderate to severe allergic asthma: must submit patients weight, must have IgE level greater than or equal to 30 IU/mL AND positive skin or RAST test to perennial aeroallergen. Must have trial of combination therapy with an ICS/LABA (inhaled corticosteroid/long-acting beta-agonist, such as Breo Ellipta, Dulera, or fluticasone-salmeterol) AND either a LAMA (long-acting muscarinic antagonist, such as Spiriva) or a leukotriene receptor antagonist (such as montelukast) with inadequate response or significant side effects/toxicities or have a contraindication to these therapies within the last year. Must have asthma symptoms that continue to be uncontrolled (uncontrolled defined as hospitalization for asthma within past year, requirement for oral or parenteral corticosteroids to control exacerbations of asthma on 2 occurrences in the past year, or need for daily corticosteroid with inability to taper off). For chronic idiopathic urticaria: must have chart documentation showing 3-month history of urticaria w/ presence of hives, must have trial of one 2nd generation H1 antihistamine (e.g. levocetirizine) and one leukotriene antagonist (e.g. montelukast) with inadequate responses or significant side effects/toxicity unless contraindicated. For nasal polyps: must have trial of at least one nasal corticosteroid (e.g. fluticasone) and must be used as add-on maintenance treatment. For food allergy: must have baseline IgE level, must have documentation confirming diagnosis due to food exposure. For reauth: must have documentation from prescriber indicating improvement in condition.
Age Restrictions	Persistent asthma: 6 years of age or older. Idiopathic urticaria: 12 years of age or older. Nasal polyps: 18 years of age or older. Food allergy: 1 year of age or older.
Prescriber Restrictions	Urticaria: allergist, dermatologist, immunologist. Asthma, Nasal Polyps: no prescriber restrictions. Food allergy: allergist or immunologist.
Coverage Duration	Urticaria, Nasal Polyps, Food allergy: 90 days initial, 365 days reauth. Asthma: 365 days.
Other Criteria	For asthma: must follow recommended dosing guidelines based upon weight and IgE level. For urticaria: dosages above 300mg every 4 weeks is not covered. For nasal polyps and food allergy: dosages above 600mg every 2 weeks are not covered.

Prior Authorization Group	ZELBORAF
Drug Names	ZELBORAF
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. For Erdheim-Chester disease, must have chart documentation of lab result confirming BRAF V600 mutation. For unresectable or metastatic melanoma: must have chart documentation of lab result confirming BRAF V600E mutation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ZTALMY
Drug Names	ZTALMY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) confirmed by genetic testing. Must have had an inadequate response or intolerance to 2 generic antiepileptic drugs (e.g. lamotrigine, topiramate, felbamate).
Age Restrictions	Age 2 years or older
Prescriber Restrictions	By or in consultation with a neurologist.
Coverage Duration	365 days
Other Criteria	Not Applicable

Prior Authorization Group	ZURZUVAE
Drug Names	ZURZUVAE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Must not have a history of bipolar disorder, psychotic disorders, attempted suicide, or risk of suicide in the current post-partum depression episode
Required Medical Information	Diagnosis. Must have a diagnosis during postpartum period for moderate to severe depression that has onset in the third trimester or within the 4 weeks postpartum. Chart documentation must include a medical evaluation to rule out other medical conditions that may have symptoms similar to depression (such as thyroid dysfunction or vitamin deficiencies). Reauthorization: None, initial criteria apply.
Age Restrictions	18 years or older
Prescriber Restrictions	Must be prescribed by or in consultation with a psychiatrist or obstetrician
Coverage Duration	2 weeks
Other Criteria	Not applicable

Prior Authorization Group	ZYKADIA
Drug Names	ZYKADIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	No Exclusion Criteria
Required Medical Information	Diagnosis. Must have chart documentation of lab result confirming ALK mutation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	365 days
Other Criteria	Not Applicable