Products Affected

- *adapalene 0.1% cream*
- *adapalene/benzoyl peroxide 0.1-2.5% gel*
- *avita 0.025% gel*
- *tretinoin 0.025% cream*
- *tretinoin 0.04% gel*
- *tretinoin 0.05% gel*
- *tretinoin 0.1% gel*
- *adapalene 0.3% gel*
- *avita 0.025% cream*
- *tretinoin 0.01% gel*
- *tretinoin 0.025% gel*
- *tretinoin 0.05% cream*
- *tretinoin 0.1% cream*

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) For rheumatoid arthritis: Intolerance to, or failure of therapy with, 2 of the following: a) Enbrel, b) Humira, c) Rinvoq OR d) Xeljanz. B) For polyarticular juvenile idiopathic arthritis: Intolerance to, or failure of therapy with 2 of the following: a) Humira, b) Enbrel OR c) Xeljanz. C) For Giant Cell Arteritis: trial of other agents not required. D) For systemic sclerosis-associated interstitial lung disease: a) Diagnosis is confirmed with documentation provided of both of the following: i) HRCT scan AND ii) pulmonary function tests AND b) Member has trial and failed mycophenolate. E) For systemic juvenile idiopathic arthritis: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, polyarticular juvenile idiopathic arthritis, systemic juvenile idiopathic arthritis, and giant cell arteritis: Prescribed by, or in consultation with, a rheumatology specialist. For systeic sclerosis-associated interstitial lung disease: Prescribed by, or in consultation with, a pulmonologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

– ADBRY 150MG/ML SYRINGE

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

Products Affected

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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) Diagnosis confirmed by right heart catheterization. B) For pulmonary arterial hypertension: Intolerance to, or failure of, therapy with both of the following: one ERA (ambrisentan, bosentan or macitentan (Opsumit)) AND one PDE5-inhibitor (sildenafil or tadalafil). C) For persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4), no prior therapy required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Both of the following: A) Member has 4 or more migraine days per month for the previous 3 months or longer AND B) Member has tried and failed an 8-week or greater trial of 2 of the 3 following drug classes: a) anticonvulsants, b) vasoactive agents, OR c) antidepressants. For continuation requests: Prescriber attests to improvement in the member's condition with use of the medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– ALECENSA 150MG CAP (New Starts Only)

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

Products Affected

– *nitazoxanide 500mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For diarrhea due to giardiasis: trial of metronidazole or tinidizole is required. For diarrhea due to cryptosporidiosis, trial of metronidazole or tinidizole NOT required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

– ARCALYST 220MG INJ

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

Products Affected

– ARIKAYCE 590MG/8.4ML INH SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has failed to achieve negative sputum cultures after at least 6 months of multidrug regimen therapy for MAC lung disease.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist or pulmonologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- AUSTEDO 12MG TAB
- AUSTEDO 6MG TAB
- AUSTEDO 9MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) For tardive dyskinesia: i) Member has failed to respond to a change, or is unable to switch current antidopaminergic therapy. B) For chorea associated with Huntington's disease: Member has intolerance to, or failure of therapy with, tetrabenazine.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or psychiatrist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of susceptible FGFR2 or FGFR3 genetic alteration.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- *rufinamide 200mg tab (New Starts Only)*
- *rufinamide 400mg tab (New Starts Only)*
- *rufinamide 40mg/ml susp (New Starts Only)*

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

Products Affected

– BAXDELA 450MG TAB

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Member has severe active CNS lupus OR member is taking other biologics.
Required Medical Info	For systemic lupus erythematosus initial requests: A) Member is required to be taking a concurrent corticosteroid unless contraindicated AND B) Trial and failure of one of the following: a) hydroxychloroquine, b) methotrexate, c) azathioprine OR d) mycophenolate. For continuation requests (all diagnoses): Prescriber attests to improvement in the member's condition with use of the medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatologist, nephrologist, or dermatologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	Will not be used in combination with voclosporin (Lupkynis). For lupus erythematosus initial therapy: Diagnosis of active systemic lupus erythematosus is confirmed by one of the following: A) anti-double stranded DNA value greater than 30 IU/mL OR B) low complement (C3/C4) OR C) positive for anti-Smith antibodies. For lupus erythematosus continuation therapy: lab values not required. For active lupus nephritis: Lab values not required.

Products Affected

- BENZNIDAZOLE 100MG TAB
- BENZNIDAZOLE 12.5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 3 months.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has failed, is intolerant, or has a contraindication to one of the following: A) hydroxyurea OR B) peginterferon alfa-2a.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

- BRAFTOVI 75MG CAP (New Starts Only)

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

Products Affected

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

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

Products Affected

– BRUKINSA 80MG CAP (New Starts Only)

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

Products Affected

- BYLVAY 1200MCG CAP
- BYLVAY 200MCG ORAL PELLET
- BYLVAY 400MCG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: a) Diagnosis of progressive familial intrahepatic cholestasis confirmed by genetic testing (documentation is provided) AND b) Genetic testing does not indicate presence of ABCB11 variants that result in non-functional or complete absence of the BSEP-3 protein. For continuation requests: Prescriber attests to improvement in the member's condition with use of the medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hepatologist, gastroenterologist, or provider that specializes in progressive familial intrahepatic cholestasis.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– CABLIVI 11MG INJ

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

Products Affected

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

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

Products Affected

- *calcipotriene 0.005% cream*
- *calcipotriene 0.005% ointment*
- *calcipotriene 0.005% topical soln*

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For schizophrenia: Patient has tried and failed 2 of the following: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone OR e) ziprasidone. For bipolar depresssion: Patient has tried and failed both of the following: a) lurasidone (Latuda) AND b) quetiapine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

– *carglumic acid 200mg tab for oral susp*

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

Products Affected

– CAYSTON 75MG INH SOLN

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

Products Affected

– CERDELGA 84MG CAP

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

Products Affected

- CHOLBAM 250MG CAP
- CHOLBAM 50MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Initial will be 3 months, then if criteria is met approved for the rest of the plan year.
Other Criteria	Renewal requires documentation is provided of stable or improved liver function.

Products Affected

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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Rheumatoid Arthritis (RA): Intolerance to or failure of therapy with 2 of the following: a) Humira, b) Enbrel c) Rinvoq OR d) Xeljanz. For Ankylosing Spondylitis (AS): Intolerance to or failure of therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz d) Rinvoq OR e) Xeljanz. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Stelara, e) Otezla, f) Skyrizi, g) Tremfya, h) Rinvoq OR i) Xeljanz. For Plaque Psoriasis: Intolerance to or failure of therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Skyrizi, e) Stelara, f) Tremfya OR f) Otezla. For Crohn's Disease: Intolerance to or failure of therapy with 2 of the following: a) Humira, b) Stelara, OR c) Skyrizi. For Non-radiographic axial spondyloarthritis: Intolerance or failure of therapy with two non-steroidal anti-inflammatory drugs (NSAIDs).
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis, Non-radiographic axial spondyloarthritis or Ankylosing Spondylitis: Prescribed by, or in consultation, with a rheumatology specialist. For Crohn's Disease: Prescribed by, or in consultation with, a gastroenterology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatology specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- COTELLIC 20MG TAB (New Starts Only)

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

Products Affected

– CYSTADROPS 0.37% OPHTH SOLN

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

Products Affected

– CYSTARAN 0.44% OPHTH SOLN

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: For Atopic Dermatitis: Intolerance to, or failure of therapy of two (2) of the following: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant (trial of other agents not required for patients under 2 years of age). For Asthma: Prescriber attests that member has a history, within the last year, of at least 1 asthma exacerbation requiring one of the following: a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For nasal polyps: Intolerance to, or failure of therapy of both of the following: a) an oral corticosteroid AND b) a nasal corticosteroid. For eosinophilic esophagitis: Trial of a topical corticosteroid was ineffective, not tolerated, or contraindicated. For continuation requests (all diagnoses): Prescriber attests to improvement in the member's condition with use of the medication. For all indications: Will not be used in combination with other targeted immunomodulators.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an allergist, gastroenterologist, immunologist, pulmonologist, dermatologist or ENT specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	For initial requests: For atopic dermatitis: Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For asthma: Member has one of the following: 1) moderate to severe asthma with an eosinophilic phenotype (baseline blood eosinophil concentration is provided and is greater than or equal to 150 cells/mL) OR 2) member has oral corticosteroid-dependent asthma. For nasal polyps, both of the following: A) Bilateral nasal polyposis confirmed with sinus CT scan AND B) Prescriber attests to moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). For eosinophilic esophagitis, both of the following: A) endoscopic biopsy with at least 15 eosinophils per high-power field (hpf) AND B) symptoms of esophageal dysfunction (e.g. dysphagia)

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For migraine initial requests: Both of the following: A) Member has 4 or more migraine days per month for the previous 3 months or longer AND B) Member has tried and failed an 8-week or greater trial of 2 of the 3 following drug classes: a) anticonvulsants, b) vasoactive agents, OR c) antidepressants. For episodic cluster headache prophylaxis initial requests: Member has tried and failed verapamil. For continuation requests (all diagnoses): Prescriber attests to improvement in the member's condition with use of the medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 20mg/week required (or maximally tolerated dose). For Juvenile Idiopathic Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose). For Plaque Psoriasis: Failure of, or intolerance to therapy with one of the following: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For Ankylosing Spondylitis (AS): Failure of, or intolerance to sulfasalazine (Trial of sulfasalazine not required for AS with predominant axial involvement). For Psoriatic Arthritis: Failure of, or intolerance to one of the following: a) methothrexate OR b) sulfasalazine.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– ENDARI 5GM POWDER FOR ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Criteria 1 and 2 must be met or criteria 3 must be met: 1. Trial of maximally tolerated hydroxyurea dose was ineffective, not tolerated or contraindicated. 2. Member has had at least 1 vaso-occlusive crises in the prior 12 months, while on hydroxyurea (if applicable). 3. Prescriber is a hematologist at a Sickle Cell Center of Excellence (Documentation is provided of the name of the center of excellence). For continuation requests: Prescriber attests to improvement in the member's condition with use of the medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– ENSPRYNG 120MG/ML SYRINGE

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

Products Affected

– SOFOSBUVIR/VELPATASVIR 400-100MG TAB

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

Products Affected

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

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

Products Affected

– ERIVEDGE 150MG CAP (New Starts Only)

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

Products Affected

– ERLEADA 60MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic castration-sensitive prostate cancer (mCSPC): failure of or intolerance to abiraterone (Zytiga equivalent) required. For nonmetastatic castration-resistant prostate cancer (nmCRPC): no prior agent trial required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

– EVRYSDI 0.75MG/ML ORAL SOLN

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

Products Affected

– EXKIVITY 40MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of EGFR exon 20 insertion mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed 2 of the following: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone OR e) ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: A) Peripheral blood eosinophil count is provided and greater than or equal to 150 cells per microliter. B) History of one (1) or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s). For continuation requests: Prescriber attests to improvement in the member's condition with use of the medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an allergy specialist, immunologist, or pulmonary specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- *deferiprone 1000mg tab*
- FERRIPROX 1000MG TAB
- *deferiprone 500mg tab*
- FERRIPROX 100MG/ML ORAL SOLN

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

Products Affected

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

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

Products Affected

- FIRDAPSE 10MG TAB

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- GALAFOLD 123MG 28 DAY PACK

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

Products Affected

- GATTEX 5MG INJ

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

Products Affected

– GAVRETO 100MG CAP (New Starts Only)

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

Products Affected

– GEMTESA 75MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial and failure or intolerance to both of the following: a) Myrbetriq AND b) one antimuscarinic agent.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

- GENOTROPIN 0.2MG SYRINGE
- GENOTROPIN 0.4MG SYRINGE
- GENOTROPIN 0.6MG SYRINGE
- GENOTROPIN 0.8MG SYRINGE
- GENOTROPIN 1.2MG SYRINGE
- GENOTROPIN 1.4MG SYRINGE
- GENOTROPIN 1.6MG SYRINGE
- GENOTROPIN 1.8MG SYRINGE
- GENOTROPIN 12MG CARTRIDGE
- GENOTROPIN 1MG SYRINGE
- GENOTROPIN 2MG SYRINGE
- GENOTROPIN 5MG CARTRIDGE

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

Products Affected

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

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

Products Affected

- HETLIOZ 4MG/ML SUSP
- *tasimelteon 20mg cap*

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

Products Affected

- JUXTAPID 10MG CAP
- JUXTAPID 20MG CAP
- JUXTAPID 30MG CAP
- JUXTAPID 5MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: A) One of the following: i) Untreated LDL greater than 500 mg/dL OR ii) treated LDL greater than or equal to 300 mg/dL. B) Concurrent use of maximum statin dose (atorvastatin or rosuvastatin) and one other lipid lowering agent (dates and reasons for discontinuation are provided). For patients with statin intolerance, concurrent use of maximum statin dose not required. C) Documentation is provided showing the most recent full lipid panel, including Apo-B, from within the past 12 months. For continuation requests: Member had a reduction in low-density lipoprotein cholesterol (LDL-C) with use of the medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a lipidologist, cardiologist, or an endocrinologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- HUMIRA 10MG/0.1ML SYRINGE
- HUMIRA 20MG/0.2ML SYRINGE
- HUMIRA 40MG/0.4ML AUTO-INJECTOR
- HUMIRA 40MG/0.4ML SYRINGE
- HUMIRA 40MG/0.8ML AUTO-INJECTOR
- HUMIRA 40MG/0.8ML SYRINGE
- HUMIRA 80MG/0.8ML AUTO-INJECTOR
- HUMIRA PEDIATRIC CROHN'S STARTER PACK SYRINGE (2) 40MC
- HUMIRA PEN - CROHN'S STARTER PACK 40MG/0.8ML INJ
- HUMIRA PEN - CROHN'S STARTER PACK 80MG/0.8ML INJ
- HUMIRA PEN - PEDIATRIC UC STARTER PACK 80MG/0.8ML INJ
- HUMIRA PEN - PSORIASIS STARTER PACK 40MG/0.8ML
- HUMIRA PEN 80MG/0.8ML AND 40MG/0.4ML - PSORIASIS/UVEITI
- HUMIRA PREFILLED SYRINGE 80MG/0.8ML STARTER PACK - PEI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 20mg/week required (or maximally tolerated dose). For Juvenile Idiopathic Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose). For Plaque Psoriasis: Failure of, or intolerance to therapy with one of the following: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) acitretin. For Ankylosing Spondylitis (AS): Failure of, or intolerance to sulfasalazine (Trial of sulfasalazine not required for AS with predominant axial involvement). For Psoriatic Arthritis: Failure of, or intolerance to one of the following: a) methothrexate OR b) sulfasalazine. For Ulcerative Colitis or Crohn's Disease: Trial of other agents not required. For Hidradenitis Suppurativa (HS): Member must have both of the following: a) At least 3 cysts AND b) failure of therapy with at least one (1) oral antibiotic. For Uveitis: Failure of, or intolerance to, therapy with both of the following: a) a corticosteroid AND b) an immunosuppressant (methotrexate or cyclosporine).
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For Plaque Psoriasis and Hidradenitis Suppurativa(HS): Prescribed by, or in consultation with, a dermatology specialist. For Crohn's Disease and Ulcerative Colitis: Prescribed by, or in consultation with, a gastroenterology specialist. For Uveitis: Prescribed by, or in consult with, a rheumatology specialist OR ophthalmologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- INVEGA 1092MG/3.5ML SYRINGE (New Starts Only)
- INVEGA 1560MG/5ML SYRINGE (New Starts Only)
- INVEGA 234MG/1.5ML SYRINGE (New Starts Only)
- INVEGA 39MG/0.25ML SYRINGE (New Starts Only)
- INVEGA 546MG/1.75ML SYRINGE (New Starts Only)
- INVEGA 819MG/2.625ML SYRINGE (New Starts Only)
- INVEGA 117MG/0.75ML SYRINGE (New Starts Only)
- INVEGA 156MG/ML SYRINGE (New Starts Only)
- INVEGA 273MG/0.875ML SYRINGE (New Starts Only)
- INVEGA 410MG/1.315ML SYRINGE (New Starts Only)
- INVEGA 78MG/0.5ML SYRINGE (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has established tolerability with the oral version of medication being requested.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- IMBRUVICA 140MG CAP (New Starts Only)
- IMBRUVICA 420MG TAB (New Starts Only)
- IMBRUVICA 560MG TAB (New Starts Only)
- IMBRUVICA 70MG CAP (New Starts Only)
- IMBRUVICA 70MG/ML SUSP (New Starts Only)

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

Products Affected

– IMPAVIDO 50MG CAP

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

Products Affected

– INCRELEX 40MG/4ML INJ

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

Products Affected

- INGREZZA 40MG CAP
- INGREZZA 60MG CAP
- INGREZZA 80MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) One of the following: i) Member has failed to respond to a change in current antidopaminergic therapy OR ii) Member is unable to switch current antidopaminergic therapy OR iii) Member has symptoms of tardive dyskinesia and is not using antidopaminergic therapy B) Member has a functional disability due to tardive dyskinesia.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or psychiatrist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

– INQOVI 5 TABLET PACK (New Starts Only)

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

Products Affected

– INREBIC 100MG CAP (New Starts Only)

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

Products Affected

- IRESSA 250MG TAB (New Starts Only)

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

Products Affected

- ISTURISA 10MG TAB
- ISTURISA 1MG TAB
- ISTURISA 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Trial and failure or intolerance to ketoconazole. For continuation requests: Documentation is provided of urinary cortisol levels that show a positive clinical response.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an endocrinologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– *ivermectin 3mg tab*

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- JYNARQUE 15MG TAB
- JYNARQUE TAB 15/15 CARTON PACK (56)
- JYNARQUE TAB 45/15 CARTON PACK (28)
- JYNARQUE TAB 90/30 CARTON PACK (28)
- JYNARQUE 30MG TAB
- JYNARQUE TAB 30/15 CARTON PACK (28)
- JYNARQUE TAB 60/30 CARTON PACK (28)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has an eGFR of 25 ml/min/1.73m2 or greater.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

- KERENDIA 10MG TAB
- KERENDIA 20MG TAB

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis: Intolerance to, or failure of therapy with, 2 of the following: a) Humira, b) Enbrel, c) Rinvoq OR d) Xeljanz
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatology specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

– KORLYM 300MG TAB

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

Products Affected

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

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

Products Affected

– KRAZATI 200MG TAB (New Starts Only)

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuation therapy: Prescriber attests to improvement in the member's condition with use of the medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a medical geneticist or metabolic physician.
Coverage Duration	Initial approval of 3 months. Continuing therapy approved for duration of contract year.
Other Criteria	

Products Affected

- KYNMOBI 10MG SL FILM
- KYNMOBI 15MG SL FILM
- KYNMOBI 20MG SL FILM
- KYNMOBI 25MG SL FILM
- KYNMOBI 30MG SL FILM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has failed both of the following: a) rasagiline AND b) entacapone.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

– *lidocaine 5% patch*

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

Products Affected

– *lidocaine 5% ointment*

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

Products Affected

– LIVMARLI 9.5MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Documentation is provided of a mutation in one of the following: a) JAG1 gene OR b) NOTCH2 gene. For continuation requests: Prescriber attests to improvement in the member's condition with use of the medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hepatologist, gastroenterologist, or provider that specializes in the treatment of Alagille syndrome.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– LIVTENCITY 200MG TAB

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

– LUMAKRAS 120MG TAB (New Starts Only)

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

Products Affected

– LUPKYNIS 7.9MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuation therapy: Prescriber attests to improvement in the member's condition with use of the medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatologist or nephrologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	Will not be used in combination with belimumab (Benlysta).

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed 2 of the following: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone OR e) ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

- *megestrol acetate 125mg/ml susp*
- *megestrol acetate 40mg/ml susp*

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

Products Affected

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

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

Products Affected

- MEKINIST 0.5MG TAB (New Starts Only)
- MEKINIST 2MG TAB (New Starts Only)

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

Products Affected

- MEKTOVI 15MG TAB (New Starts Only)

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

Products Affected

– *dihydroergotamine mesylate 0.5mg/act nasal inhaler*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trials of 2 different triptans were ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of both of the following was ineffective, contraindicated, or not tolerated: A) Trulicity AND B) Ozempic.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- MOVANTIK 12.5MG TAB
- MOVANTIK 25MG TAB

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

Products Affected

- *carisoprodol 350mg tab*
- *cyclobenzaprine 10mg tab*
- *metaxalone 800mg tab*
- *methocarbamol 750mg tab*
- *chlorzoxazone 500mg tab*
- *cyclobenzaprine 5mg tab*
- *methocarbamol 500mg tab*
- *orphenadrine citrate 100mg er tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Prior Authorization applies to patients 65 years or older.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- MYFEMBREE 1-0.5-40MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For heavy menstrual bleeding due to uterine fibroids: Member has failure of, or intolerance to, one hormonal contraceptive. For pain due to endometriosis: Member has failure of, or intolerance to, both of the following: a) one non-steroidal anti-inflammatory drug (NSAID) AND b) one hormonal contraceptive.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an obstetrician/gynecologist or women's health/reproductive specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	Member does not have known osteoporosis.

Products Affected

- ABELCET 5MG/ML INJ
- *acetylcysteine 200mg/ml inh soln*
- *albuterol 0.21mg/ml (0.63mg/3ml) inh soln*
- *albuterol 1.25mg/3ml neb soln*
- AMPHOTERICIN B 50MG INJ
- *aprepitant 125mg/aprepitant 80mg cap therapy pack*
- *aprepitant 80mg cap*
- ASTAGRAF 0.5MG ER CAP
- ASTAGRAF 5MG ER CAP
- *azasan 75mg tab*
- *azathioprine 50mg tab*
- *budesonide 0.125mg/ml inh susp*
- *budesonide 0.5mg/ml inh susp*
- CLINIMIX 4.25/5 INJ
- CLINIMIX 5/20 INJ
- CLINIMIX E 4.25/10 INJ
- CLINIMIX E 5/15 INJ
- *clinisol 15 inj*
- CYCLOPHOSPHAMIDE 50MG TAB
- *cyclosporine 25mg cap*
- *cyclosporine modified 100mg/ml oral soln*
- *cyclosporine modified 50mg cap*
- ENGERIX-B 10MCG/0.5ML SYRINGE
- ENGERIX-B 20MCG/ML SYRINGE
- ENVARSUS XR 1MG TAB
- *everolimus 0.25mg tab*
- *everolimus 0.75mg tab*
- FIASP 100UNIT/ML INJ
- *gengraf 100mg cap*
- *acetylcysteine 100mg/ml inh soln*
- *acyclovir 50mg/ml inj*
- *albuterol 0.83mg/ml (0.083%) inh soln*
- *albuterol 5mg/ml inh soln*
- *aprepitant 125mg cap*
- *aprepitant 40mg cap*
- *arformoterol tartrate 15mcg/2ml neb soln*
- ASTAGRAF 1MG ER CAP
- *azasan 100mg tab*
- *azathioprine 100mg tab*
- *azathioprine 75mg tab*
- *budesonide 0.25mg/ml inh susp*
- CLINIMIX 4.25/10 INJ
- CLINIMIX 5/15 INJ
- CLINIMIX E 2.75/5 INJ
- CLINIMIX E 4.25/5 INJ
- CLINIMIX E 5/20 INJ
- CYCLOPHOSPHAMIDE 25MG TAB
- *cyclosporine 100mg cap*
- *cyclosporine modified 100mg cap*
- *cyclosporine modified 25mg cap*
- DIPHTHERIA/TETANUS TOXOID INJ
- ENGERIX-B 20MCG/ML INJ
- ENVARSUS XR 0.75MG TAB
- ENVARSUS XR 4MG TAB
- *everolimus 0.5mg tab*
- *everolimus 1mg tab*
- *formoterol fumarate 20mcg/2ml neb soln*
- *gengraf 100mg/ml oral soln*

- *gengraf 25mg cap*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 2MG/ML INJ
- *granisetron 1mg tab*
- HUMULIN R 500UNIT/ML INJ
- INTRALIPID 20GM/100ML INJ
- *ipratropium/albuterol 0.5-2.5mg/3ml inh soln*
- *levalbuterol 0.63mg/3ml inh soln*
- *levalbuterol 1.25mg/3ml neb soln*
- *methylprednisolone 32mg tab*
- *methylprednisolone 8mg tab*
- *mycophenolate mofetil 250mg cap*
- *mycophenolic acid 180mg dr tab*
- NOVOLOG 100UNIT/ML INJ
- *ondansetron 0.8mg/ml oral soln*
- *ondansetron 4mg tab*
- *ondansetron 8mg tab*
- *plenamine 15% inj*
- *prednisolone 3mg/ml oral soln*
- *prednisone 1mg tab*
- *prednisone 2.5mg tab*
- *prednisone 50mg tab*
- PREHEVBRIO 10MCG/ML INJ
- PROGRAF 0.2MG GRANULES FOR ORAL SUSP
- PROSOL 20% INJ
- RABAVERT 2.5UNIT/ML INJ
- RECOMBIVAX 10MCG/ML SYRINGE
- RECOMBIVAX 5MCG/0.5ML INJ
- SANDIMMUNE 100MG/ML ORAL SOLN
- *sirolimus 1mg tab*
- *sirolimus 2mg tab*
- *glucose 100mg/ml inj*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 4.5MG/ML INJ
- HEPLISAV-B 20MCG/0.5ML SYRINGE
- IMOVAX 2.5UNIT/ML INJ
- *ipratropium bromide 0.02% inh soln*
- *levalbuterol 0.31mg/3ml neb soln*
- *levalbuterol 1.25mg/0.5ml neb soln*
- *methylprednisolone 16mg tab*
- *methylprednisolone 4mg tab*
- *mycophenolate mofetil 200mg/ml susp*
- *mycophenolate mofetil 500mg tab*
- *mycophenolic acid 360mg dr tab*
- NUTRILIPID 20GM/100ML INJ
- *ondansetron 4mg odt*
- *ondansetron 8mg odt*
- *pentamidine isethionate 50mg/ml inh soln*
- *prednisolone 1mg/ml oral soln*
- *prednisone 10mg tab*
- PREDNISONE 1MG/ML ORAL SOLN
- *prednisone 20mg tab*
- *prednisone 5mg tab*
- PREMASOL 10% INJ
- PROGRAF 1MG GRANULES FOR ORAL SUSP
- PULMOZYME 1MG/ML INH SOLN
- RECOMBIVAX 10MCG/ML INJ
- RECOMBIVAX 40MCG/ML INJ
- RECOMBIVAX 5MCG/0.5ML SYRINGE
- *sirolimus 0.5mg tab*
- *sirolimus 1mg/ml oral soln*
- *tacrolimus 0.5mg cap*

- *tacrolimus 1mg cap*
- TDVAX 4-4UNIT/ML INJ
- TENIVAC 4-10UNIT/ML SYRINGE
- TROPHAMINE 10% INJ
- *tacrolimus 5mg cap*
- TENIVAC 4-10UNIT/ML INJ
- TRAVASOL 10% INJ
- VARUBI 90MG TAB

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

Products Affected

- NATPARA 100MCG CARTRIDGE
- NATPARA 25MCG CARTRIDGE
- NATPARA 50MCG CARTRIDGE
- NATPARA 75MCG CARTRIDGE

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

Products Affected

– NERLYNX 40MG TAB (New Starts Only)

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- NOURIANZ 20MG TAB
- NOURIANZ 40MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has tried and failed one agent from both of the following classes: 1) COMT inhibitor AND 2) MAO-B inhibitor.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- NOXAFIL 40MG/ML SUSP
- *posaconazole 100mg dr tab*

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

Products Affected

- NUBEQA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic hormone-sensitive prostate cancer (mHSPC): failure of or intolerance to abiraterone (Zytiga equivalent) required. For non-metastatic castration-resistant prostate cancer (nmCRPC): no prior agent trial required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For asthma initial requests: Both of the following: A) Peripheral blood eosinophil count is provided and is greater than or equal to 150 cells per microliter. B) History of 1 or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s). For eosinophilic granulomatosis with polyangiitis (EGPA) initial requests: All of the following: A) One of the following: 1) baseline blood eosinophil count greater than 1000 cells per microliter OR 2) baseline blood eosinophil count greater than 10% of the total leukocyte count B) Trial of oral corticosteroid therapy was ineffective, contraindicated, or not tolerated C) Trial of one of the following was ineffective, contraindicated, or not tolerated: a) cyclophosphamide OR b) methotrexate. For hypereosinophilic syndrome initial requests: Both of the following: A) Diagnosis confirmed by blood eosinophil count greater than 1000 cells per microliter AND B) Hypereosinophilic syndrome has persisted for at least six months. For nasal polyps initial requests: Intolerance to, or failure of therapy of both of the following: a) an oral corticosteroid AND b) a nasal corticosteroid. For continuation requests (all diagnoses): Prescriber attests to improvement in the member's condition with use of the medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an allergy specialist, immunologist, otolaryngologist, pulmonary specialist, gastroenterologist, hematologist, or rheumatologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- NUEDEXTA 20-10MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided (in the form of chart notes or imaging) of a structural neurological condition as the cause of pseudobulbar affect AND disease severity demonstrated by a score of 13 or greater on the Center for Neurologic Study Lability Scale (CNS-LS).
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Neurologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– ZOLINZA 100MG CAP (New Starts Only)

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

Products Affected

- *zolpidem tartrate 10mg tab*
- *zolpidem tartrate 5mg tab*
- *zolpidem tartrate 12.5mg er tab*
- *zolpidem tartrate 6.25mg er tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial and failure of either trazodone or mirtazapine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

- ZYKADIA 150MG TAB (New Starts Only)

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