Drugs That Drugs That Require Prior Authorization (PA)
Before Being Approved for Coverage

You will need authorization by your BlueSaver HMO, Senior Blue HMO, Freedom Nation PPO, or Forever Blue PPO plan before filling prescriptions for the drugs shown in the chart below. BlueCross BlueShield of WNY will only provide coverage after it determines that the drug is being prescribed according to the criteria specified in the chart. You, your appointed representative, or your prescriber can request prior authorization by calling Member Services at 1-800-329-2792 (TTY only, call 711). We are open October 1 - March 31 8 a.m. to 8 p.m., 7 days a week and April 1 - September 30 8 a.m. to 8 p.m., Monday - Friday. Calls to these numbers are free. You can also visit our website, www.bcbswny.com./medicare

PRIOR AUTHORIZATION MEDICATIONS	
ACTEMRA SQ	
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
Required Medical Info	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	Interstitial lung disease-18 years and older (initial and continuation)
Prescriber Restrictions	RA/GCA/PJIA/SJIA - Prescribed by or in consultation with a rheumatologist (initial therapy). Interstitial Lung disease-presc/consult-pulmonologist or rheum (initial and cont)
Coverage Duration	GCA-6mo initial,3yr cont.PJIA-4mo initial, 3yr cont.Lung dx-1 year.other dx-3mo initial, 3 yr cont.
Other Criteria	RA initial - approve if the patient has tried TWO of the following: Enbrel, Humira, Orencia, Rinvoq or Xeljanz/XR (Note: if the patient has not tried TWO of these drugs listed, previous trial(s) with the following drugs can count towards meeting the try TWO requirement: Cimzia, infliximab, golimumab SC/IV) OR if, according to the prescribing physician, the patient has heart failure or a previously treated lymphoproliferative disorder. PJIA, approve if the patient has tried TWO of the following: Enbrel, Orencia, Xeljanz or Humira. (Note: the patient does not have to have a trial with Enbrel, Orencia or Humira if they have had a trial with infliximab in the past.) OR According to the prescribing physician, the patient has heart failure or a previously treated lymphoproliferative disorder. Cont tx - pt must have had a response as determined by the prescriber. Interstitial lung disease associated with systemic sclerosis initial-approve if the patient has elevated acute phase reactants AND the diagnosis is confirmed by high-resolution computed tomography. Continuation-approve if the patient had adequate efficacy, demonstrated by less than or equal to 10 percent decrease in predicted forced vital capacity (FVC) over the past year while on Actemra.
Indications	All FDA-approved Indications.

Off-Label Uses	
ACYCLOVIR (TOPICAL)	
Exclusion Criteria	
Required Medical Info	Medication history
Age Restrictions	acyclovir 5% cream, 12 yrs or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
ADEMPAS	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	PAH and CTEPH- must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	1 year
Other Criteria	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1).
Indications	All FDA-approved Indications.
Off-Label Uses	
AFINITOR	
Exclusion Criteria	
Required Medical Info	Breast Cancer-HER2 status, hormone receptor (HR) status.
Age Restrictions	Relapsed or refractory classical Hodgkin lymphoma-18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.

Other Criteria	Breast Cancer-approve if the patient meets ALL the following criteria (A, B, C, D, E, and F): A)patient has recurrent or Stage IV, hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)] disease AND B)patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND C)patient has tried at least one prior endocrine therapy (e.g., anastrozole, letrozole, or tamoxifen) AND D)patient meets ONE of the following conditions (i or ii): i. patient is a postmenopausal female or a male OR ii. patient is premenopausal or perimenopausal AND is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex (goserelin]), or has had surgical bilateral oophorectomy or ovarian irradiation AND E)patient meets ONE of the following conditions (i or ii): i. If patient is a male AND if everolimus will be used in combination with exemestane, the patient is receiving a gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex (goserelin]) OR ii. everolimus will be used in combination with exemestane, Faslodex (fulvestrant intramuscular), or tamoxifen AND F) The patient has not had disease progression while on everolimus.Renal Cell Carcinoma (Clear Cell or Non-clear cell histology)-approve if the patient has relapsed or Stage IV disease and if using for clear cell disease, the patient has tried one prior systemic therapy (e.g., Inlyta, Votrient, Sutent, Cabometyx, Nexavar). Tuberous sclerosis complex (TSC) Associated subependymal giant cell astrocytoma (SEGA)-approve if the patient requires therapeutic intervention but cannot be curatively resected. Thymomas and Thymic Carcinomas-approve if the patient has tried one prior chemotherapy (e.g., cisplatin plus doxorubicin, cisplatin plus etoposide, carboplatin plus paclitaxel).TSCassociated renal angiomyolipoma-approve.WM/LPL - approve if patient has progressive or relapsed disease or if the patient has not responded to ONE primary therapy (e.g., Velcade with dexamethasone with or without Rituxan, Treanda with Rituxan, Rituxan with cyclophosphamide and dexamethasone, Treanda, Velcade with or without Rituxan, Velcade with dexamethasone, Kyprolis with Rituxan and dexamethasone, Imbruvica Rituxan). Differentiated (i.e. papillary, follicular, and Hurthle cell) Thyroid Carcinoma-approve if the patient is refractory to radioactive iodine therapy.Endometrial Carcinoma-approve if everolimus will be used in combination with letrozole and the patient has recurrent, metastatic or high-risk disease. GIST-approve if the patient has tried TWO of the following drugs: Sutent, Stivarga, or imatinib AND there is confirmation that everolimus will be used in combination with one of these drugs (Sutent, Stivarga, or imatinib) in the treatment of GIST.Tuberous sclerosis complex (TSC)-associated partial-onset seizures-approve.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Advanced, unresectable or metastatic neuroendocrine tumors of the thymus (Carcinoid tumors). Perivascular Epitheloid Cell Tumors (PEComa), Recurrent Angiomyolipoma, Lymphangioleiomyomatosis, relapsed or refractory classical Hodgkin lymphoma, Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma (WM/LPL), Thymomas and Thymic carcinomas, Differentiated (i.e. papillary, follicular, and Hurthle cell) Thyroid Carcinoma, Endometrial Carcinoma, Gastrointestinal Stromal Tumors (GIST) and Recurrent or progressive Meningioma, men with breast cancer

AIMOVIG	
Exclusion Criteria	Combination therapy with Ajovy, Vyepti or Emgality
Required Medical Info	Diagnosis, number of migraine headaches per month, prior therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least two standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and has had inadequate responses to those therapies or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	
AJOVY	
Exclusion Criteria	Combination therapy with Aimovig, Vyepti or Emgality
Required Medical Info	Diagnosis, number of migraine headaches per month, prior therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least two standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and has had inadequate responses to those therapies or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	
ALECENSA	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	metastatic NSCLC - is anaplastic lymphoma kinase (ALK)-positive as detected by an approved test.

Indications	All FDA-approved Indications.
Off-Label Uses	
ALUNBRIG	
Exclusion Criteria	
Required Medical Info	ALK status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Metastatic NSCLC, must be ALK-positive, as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	
AMPYRA	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	MS. If prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
ANABOLIC STEROIDS	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients w/Turner's Syndrome or Ullrich-Turner Syndrome (oxandrolone only), management of protein catabolism w/burns or burn injury (oxandrolone only), AIDS wasting and cachexia
ANTIBIOTICS (IV)	
Exclusion Criteria	

Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
ANTIFUNGALS (IV)	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
APOKYN	
Exclusion Criteria	Concurrent use with a serotonin 5-HT3 Antagonist
Required Medical Info	Diagnosis, other therapies
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Parkinson's disease (PD)-approve if the patient has advanced PD, is experiencing off episodes such as muscle stiffness, slow movements, or difficulty starting movements, is currently receiving carbidopa/levodopa and has previously tried one other treatment for off episodes.
Indications	All FDA-approved Indications.
Off-Label Uses	
ARANESP	
Exclusion Criteria	

Required Medical Info	Anemia w/CRF not on dialysis.A hemoglobin (Hb) of less than 10.0 g/dL for adults and less than or equal to 11 g/dL for children required for start,Hb has to be less than or equal 11.5 g/dL adults or less than or equal to 12 g/dL in children if previously receiving epoetin alfa (EA), Mircera or Aranesp. Anemia due to myelosuppressive chemotx,Hb is 10.0 g/dL or less to start or less than or equal to 12.0 g/dL if previously on EA or Aranesp AND currently receiving myelosuppressive chemo. MDS, approve tx if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start. If the pt has previously been receiving Aranesp or EA, approve only if Hb is 12.0 g/dL or less. All conds, deny if Hb exceeds 12.0 g/dL.
Age Restrictions	MDS anemia = 18 years of age and older.
Prescriber Restrictions	MDS anemia, prescribed by or in consultation with, a hematologist or oncologist.
Coverage Duration	Anemia w/myelosupp=6 mos, Anemia with CKD (dialysis)-3 years, no dialysis, MDS-1 year, Other=6 mos.
Other Criteria	For all covered uses, the patient is required to try Procrit or Retacrit first line.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Anemia due to myelodysplastic syndrome (MDS)
ARCALYST	
Exclusion Criteria	Concurrent biologic therapy
Required Medical Info	
Age Restrictions	Initial tx CAPS/Pericarditis-Greater than or equal to 12 years of age.
Prescriber Restrictions	Initial tx CAPS-prescribed by, or in consultation with, a rheumatologist, geneticist, allergist/immunologist, or dermatologist. DIRA initial-rheum, geneticist, derm, or a physician specializing in the treatment of autoinflammatory disorders. Pericarditis-cardiologist or rheum
Coverage Duration	CAPS-3 mo initial, 3 years cont. DIRA-6 mo initial, 3 years cont.Pericard-3 mo initial, 1 yr cont
Other Criteria	CAPS renewal - approve if the patient has had a response as determined by the prescriber. DIRA initial-approve if the patient weighs at least 10 kg, genetic test confirms a mutation in the IL1RN gene and the patient has demonstrated a clinical benefit with anakinra subcutaneous injection. DIRA cont-approve if the patient has responded to therapy. Pericarditis initial-approve if the patient has recurrent pericarditis AND for the current episode, the patient is receiving standard treatment or standard treatment is contraindicated. Continuation-approve if the patient has had a clinical response.
Indications	All FDA-approved Indications.
Off-Label Uses	
ARIKAYCE	
Exclusion Criteria	
Required Medical Info	Diagnosis, previous medication history
Age Restrictions	MAC-18 years and older

Prescriber Restrictions	MAC-Prescribed by a pulmonologist, infectious disease physician or a physician who specializes in the treatment of MAC lung infections. Cystic fibrosis-prescribed by or in consultation with a pulmonologist or physician who specializes in the treatment of cystic fibrosis
Coverage Duration	1 year
Other Criteria	MAC Lung disease-approve if the patient has NOT achieved negative sputum cultures for Mycobacterium avium complex after a background multidrug regimen AND Arikayce will be used in conjunction to a background multidrug regimen. Note-a multidrug regimen typically includes a macrolide (azithromycin or clarithromycin), ethambutol and a rifamycin (rifampin or rifabutin). Cystic fibrosis-patient has pseudomonas aeruginosa in culture of the airway.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Cystic fibrosis pseudomonas aeruginoa infection
AUBAGIO	
Exclusion Criteria	Concurrent use of Aubagio with other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Info	Relapsing form of MS, to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
AVONEX	
Exclusion Criteria	Concurrent use of other disease-modifying agent used for multiple sclerosis
Required Medical Info	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
AYVAKIT	
Exclusion Criteria	

Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	GIST-approve if the tumor is positive for platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation. Myeloid/Lymphoid Neoplasms with eosinophilia-approve if the tumor is positive for platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Myeloid/Lymphoid neoplasms with Eosinophilia
BAFIERTAM	
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of MS.
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
BALVERSA	
Exclusion Criteria	
Required Medical Info	Diagnosis, previous therapies, test results
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Urothelial Carcinoma, locally advanced or metastatic-approve if the patient has susceptible fibroblast growth factor receptor 3 or fibroblast growth factor receptor 2 genetic alterations AND the patient has progressed during or following prior platinum-containing chemotherapy or checkpoint inhibitor therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	
BANZEL	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	Patients 1 years of age or older

Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Initial therapy-approve if the patient has tried and/or is concomitantly receiving at least two other antiepileptic drugs. Continuation-approve if the patient is responding to therapy
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Treatment-Refractory Seizures/Epilepsy
BENLYSTA	
Exclusion Criteria	Concurrent Use with Other Biologics
Required Medical Info	Diagnosis, medications that will be used in combination, autoantibody status
Age Restrictions	18 years and older (initial).
Prescriber Restrictions	SLE-Prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist or dermatologist (initial and continuation). Lupus Nephritis-nephrologist or rheum. (Initial/cont)
Coverage Duration	SLE-Initial-4 months, cont-3 years. Lupus Nephritis-6 mo initial, 1 year cont
Other Criteria	Lupus Nephritis Initial-approve if the patient has autoantibody-positive SLE (i.e., positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA]). Cont-approve if the patient has responded to the requested medication. SLE-Initial-The patient has autoantibody-positive SLE (i.e., positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA]) AND Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician. Continuation-Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician AND The patient has responded to Benlysta as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	
BETASERON/EXTAVIA	
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple sclerosis
Required Medical Info	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.

Coverage Duration	Authorization will be for 3 years.
Other Criteria	For patients requesting Betaseron, approve if the patient has tried two of the following: interferon beta-1a intramuscular (Avonex), interferon beta-1a subcutaneous (Rebif), pegylated interferon beta-1a (Plegridy) or glatiramer acetate (Copaxone).
Indications	All FDA-approved Indications.
Off-Label Uses	
BOSULIF	
Exclusion Criteria	
Required Medical Info	Diagnosis. For CML/ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For ALL, prior therapies tried
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, patient must have Ph-positive CML For ALL, patient must have Ph-positive ALL and has tried ONE other tyrosine kinase inhibitors that are used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Phildelphia chromosome positive Acute Lymphoblastic Leukemia
BRAFTOVI	
Exclusion Criteria	
Required Medical Info	Diagnosis, BRAF V600 status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation. Colon or Rectal cancer-approve if the patient meets the following (A, B, and C): A) The patient has BRAF V600E mutation-positive disease AND B) The patient has previously received a chemotherapy regimen for colon or rectal cancer AND C) The agent is prescribed as part of a combination regimen for colon or rectal cancer.
Indications	All FDA-approved Indications.
Off-Label Uses	
BRUKINSA	
Exclusion Criteria	
Required Medical Info	Diagnosis, prior therapies

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Mantle Cell Lymphoma - approve for 3 years if the patient has tried at least one prior therapy. Chronic lymphocytic leukemia/small lymphocytic lymphoma-approve if the patient has tried at least one prior therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chronic lymphocytic Leukemia (CLL). Small Lymphocytic Lymphoma (SLL)
C1 ESTERASE INHIBITORS	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
CABLIVI	
Exclusion Criteria	
Required Medical Info	Diagnosis, concurrent medications
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	Approve for 12 months
Other Criteria	aTTP-approve if the requested medication was initiated in the inpatient setting in combination with plasma exchange therapy AND patient is currently receiving at least one immunosuppressive therapy AND if the patient has previously received Cablivi, he/she has not had more than two recurrences of aTTP while on Cablivi.
Indications	All FDA-approved Indications.
Off-Label Uses	
CABOMETYX	
Exclusion Criteria	
Required Medical Info	Diagnosis, histology, RET gene rearrangement status
Age Restrictions	
Prescriber Restrictions	

Coverage Duration	3 years
Other Criteria	Advance Renal Cell Carcinoma (Predominant Clear Cell or Non-Clear Cell Histology)-Approve. Hepatocellular Carcinoma-approve if the patient has been previously treated with at least one other systemic therapy (e.g., Nexavar, Lenvima). GIST-approve if the patient has previously tried imatinib or avapritinib and has also tried one of the following: sunitinib, regorafinib or ripretinib. Bone cancer-approve if the patient has Ewing sarcoma or osteosarcoma and has tried at least one previous systemic regimen.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Non-Small Cell Lung Cancer with RET Gene Rearrangements, Gastrointestinal stromal tumors (GIST), Bone cancer
CALQUENCE	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	MCL, CLL and SLL-approve. Waldenstrom's Macroglobulinamia/Lymphoplasmacytic Lymphoma-approve if the patient has tried one prior therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Waldenstrom's Macroglobulinamia/Lymphoplasmacytic Lymphoma.
CAPRELSA	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	MTC - approve. DTC - approve if refractory to radioactive iodine therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma. Non-Small Cell Lung Cancer with RET Gene Rearrangements
CARBAGLU	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	

Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist or a specialist who focuses in the treatment of metabolic diseases
Coverage Duration	NAGS-Pt meets criteria no genetic test - 3 mo. Pt had genetic test - 12 mo, other-approve for 7 day
Other Criteria	N-Acetylglutamate synthase deficiency with hyperammonemia-Approve if genetic testing confirmed a mutation leading to N-acetylglutamate synthase deficiency or if the patient has hyperammonemia. Propionic Acidemia or Methylmalonic Acidemia with Hyperammonemia, Acute Treatment-approve if the patient's plasma ammonia level is greater then or equal to 50 micromol/L and the requested medication will be used in conjunction with other ammonia-lowering therapies.
Indications	All FDA-approved Indications.
Off-Label Uses	
CAYSTON	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
Coverage Duration	1 year
Other Criteria	Approve if the patient has has Pseudomonas aeruginosa in culture of the airway (e.g., sputum culture, oropharyngeal culture, bronchoalveolar lavage culture).
Indications	All FDA-approved Indications.
Off-Label Uses	
CERDELGA	
Exclusion Criteria	
Required Medical Info	Diagnosis, lab test results
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of Gaucher disease or related disorders
Coverage Duration	1 year
Other Criteria	Approve if the patient is a cytochrome P450(CYP) 2D6 extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM) as detected by an approved test
Indications	All FDA-approved Indications.
Off-Label Uses	
CHEMET	

Exclusion Criteria	
Required Medical Info	Blood lead level
Age Restrictions	Approve in patients between the age of 12 months and 18 years
Prescriber Restrictions	Prescribed by or in consultation with a professional experienced in the use of chelation therapy (eg, a medical toxicologist or a poison control center specialist)
Coverage Duration	Approve for 2 months
Other Criteria	Approve if Chemet is being used to treat acute lead poisoning (not as prophylaxis) and prior to starting Chemet therapy the patient's blood lead level was greater than 45 mcg/dL.
Indications	All FDA-approved Indications.
Off-Label Uses	
CHENODAL	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For the treatment of gallstones, approve if the patient has tried or is currently using an ursodiol product.
Indications	All FDA-approved Indications.
Off-Label Uses	
CHOLBAM	
Exclusion Criteria	Combination Therapy with Chenodal
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with hepatologist, metabolic specialist, or GI
Coverage Duration	3 mos initial, 12 mos cont

Other Criteria	Bile acid synthesis d/o due to SEDs initial - Diagnosis based on an abnormal urinary bile acid as confirmed by Fast Atom Bombardment ionization - Mass Spectrometry (FAB-MS) analysis or molecular genetic testing consistent with the diagnosis. Cont - responded to initial Cholbam tx with an improvement in LFTs AND does not have complete biliary obstruction. Bile-Acid Synthesis Disorders Due to Peroxisomal Disorders (PDs), Including Zellweger Spectrum Disorders initial - PD with an abnormal urinary bile acid analysis by FAB-MS or molecular genetic testing consistent with the diagnosis AND has liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption (e.g., rickets). Cont - responded to initial Cholbam therapy as per the prescribing physician (e.g., improvements in liver enzymes, improVement in steatorrhea) AND does not have complete biliary obstruction.
Indications	All FDA-approved Indications.
Off-Label Uses	
CIALIS	
Exclusion Criteria	
Required Medical Info	Indication for which tadalafil is being prescribed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 mos.
Other Criteria	Benign prostatic hyperplasia (BPH), after confirmation that tadalafil is being prescribed as once daily dosing, to treat the signs and symptoms of BPH and not for the treatment of erectile dysfunction (ED).
Indications	All FDA-approved Indications.
Off-Label Uses	
CIMZIA	
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Info	Diagnosis, concurrent medications, previous therapies tried
Age Restrictions	18 years and older for CD and PP (initial therapy).
Prescriber Restrictions	All dx initial therapy only. RA/AS, prescribed by or in consultation with a rheumatologist. Crohn's disease, prescribed by or in consultation with a gastroenterologist.PsA prescribed by or in consultation with a rheumatologist or dermatologist. PP, prescribed by or in consultation with a dermatologist. nr-axSpA-prescribed by or in consultation with a rheumatologist
Coverage Duration	3 months initial, 3 years cont.

Other Criteria	AS, approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx. PsA, approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx, Stelara, Otezla, Orencia or Xeljanz/XR. RA, approve if the patient has tried two of the following: Enbrel, Humira, Orencia, Rinvoq or Xeljanz/XR. CD, approve if patient has previously tried Humira. Plaque Psoriasis-approve if the patient has tried TWO of the following: Enbrel, Humira, Skyrizi, Stelara SC, Otezla, or Cosentyx. Cont tx - approve if the patient has had a response to therapy, as according to the prescribing physician. Non-radiographic axial spondylitis (nr-axSpA)-approve if the patient has objective signs of inflammation, defined as at least one of the following: C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory OR sacroilitis reported on MRI. nr-axSpA continuation-approve if the patient has had a response as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	
CLOBAZAM	
Exclusion Criteria	
Required Medical Info	Diagnosis, other medications tried
Age Restrictions	2 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with a neurologist (initial therapy)
Coverage Duration	1 year
Other Criteria	Lennox-Gastaut Syndrome, initial therapy-patient has tried one of the following: lamotrigine, topiramate, rufinamide, felbamate, or Epidiolex. Treatment refractory seizures/epilepsy, initial therapy-patient has tried and/or is concomitantly receiving at least two other antiepileptic drugs (e.g., valproic acid, lamotrigine, topiramate, clonazepam, levetiracetam, zonisamide, felbamate). Continuation-prescriber confirms patient is responding to therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Dravet Syndrome and treatment-refractory seizures/epilepsy
COMETRIQ	
Exclusion Criteria	
Required Medical Info	Diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	MTC - approve. Non-Small Cell Lung Cancer with RET Gene Rearrangements - approve. Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma-approve if the patient's carcinoma is refractory to radioactive iodine therapy.

Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Non-Small Cell Lung Cancer with RET Gene Rearrangements, Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma
COPAXONE	
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple sclerosis
Required Medical Info	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
COPIKTRA	
Exclusion Criteria	
Required Medical Info	Diagnosis, previous therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	CLL/Follicular Lymphoma/SLL/MALT Lymphoma (gastric and non gastric)/marginal zone lymphoma-approve if the patient has tried two prior therapies
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	MALT Lymphoma (gastric and non gastric), Marginal Zone Lymphoma
COSENTYX	
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Info	Diagnosis and previous medications use
Age Restrictions	PP/AS/PSA initial - 18 years of age and older
Prescriber Restrictions	PP initial - prescribed by or in consultation with a dermatologist or rheumatologist. AS initial- by or in consultation with rheumatologist, PsA initial- by or in consultation with rheumatologist or dermatologist.
Coverage Duration	PP/AS/nr-axSpA - initial tx 3 mos, PsA-initial tx 3 mos, cont tx 3 years

Other Criteria	PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to 'step back' and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. PP/AS/PsA cont - patient must have responded, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	
COTELLIC	
Exclusion Criteria	
Required Medical Info	Melanoma initial - must have BRAF V600 mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Melanoma (unresectable, advanced or metastatic) - being prescribed in combination with Zelboraf.
Indications	All FDA-approved Indications.
Off-Label Uses	
CRESEMBA (ORAL)	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Candidiasis of the esophagus - HIV infection, sepsis
CRINONE GEL	
Exclusion Criteria	Use in patients to supplement or replace progesterone in the management of infertility.
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Secondary amenorrhea, 12 months.Support of an established pregnancy, 9 months.
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

Off-Label Uses	Support of an established pregnancy
CYSTARAN	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or a metabolic disease specialist or specialist who focuses in the treatment of metabolic diseases
Coverage Duration	1 year
Other Criteria	Approve if the patient has corneal cysteine crystal deposits confirmed by slit-lamp examination
Indications	All FDA-approved Indications.
Off-Label Uses	
CYSTEAMINE (ORAL)	
Exclusion Criteria	Concomitant use of Cystagon and Procysbi
Required Medical Info	Diagnosis, genetic tests and lab results
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist or a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
Coverage Duration	1 year
Other Criteria	Cystinosis, nephropathic-approve if the prescriber confirms the diagnosis was confirmed by genetic testing confirming a mutation of the CTNS gene OR white blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory.
Indications	All FDA-approved Indications.
Off-Label Uses	
DALIRESP	
Exclusion Criteria	
Required Medical Info	Chronic Obstructive Pulmonary Disease (COPD), medications tried.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 1 year.
Other Criteria	COPD, approve in patients who meet all of the following conditions: Patients has severe COPD or very severe COPD, AND Patient has a history of exacerbations, AND Patient has tried a medication from two of the three following drug categories: long-acting beta2-agonist (LABA) [eg, salmeterol, indacaterol], long-acting muscarinic antagonist (LAMA) [eg, tiotropium], inhaled corticosteroid (eg, fluticasone).

Indications	All FDA-approved Indications.
Off-Label Uses	
DAURISMO	
Exclusion Criteria	
Required Medical Info	Diagnosis, medications that will be used in combination, comorbidities
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	AML - approve if Daurismo will be used in combination with cytarabine AND the patient meets i. OR ii: i. patient is using Daurismo for treatment induction and is greater than or equal to 75 years old or the patient has comorbidities that preclude the use of intensive induction chemotherapy according to the prescribing physician, OR ii. patient is continuing Daurismo as post-induction therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients continuing Daurismo as post-induction therapy
DOPTELET	
Exclusion Criteria	
Required Medical Info	Diagnosis, platelet count, date of procedure
Age Restrictions	18 years and older (for chronic ITP-initial therapy only)
Prescriber Restrictions	Chronic ITP-prescribed by or after consultation with a hematologist (initial therapy)
Coverage Duration	Thrombo w/chronic liver disease-5 days, chronic ITP-initial-3 months, cont-1 year
Other Criteria	Thrombocytopenia with chronic liver disease-Approve if the patient has a current platelet count less than 50 x 109/L AND the patient is scheduled to undergo a procedure within 10 to 13 days after starting Doptelet therapy. Chronic ITP initial-approve if the patient has a platelet count less than 30,000 microliters or less than 50,000 microliters and is at an increased risk of bleeding and has tried one other therapy or if the patient has undergone splenectomy. Continuation-approve if the patient demonstrates a beneficial clinical response and remains at risk for bleeding complications.
Indications	All FDA-approved Indications.
Off-Label Uses	
DUPIXENT	
Exclusion Criteria	Concurrent use with Xolair or another Anti-interleukin (IL) Monoclonal Antibody.
Required Medical Info	Diagnosis, prescriber specialty, other medications tried and length of trials
Age Restrictions	AD-6 years and older, asthma-12 years of age and older. Chronic Rhinosinusitis-18 years of age and older

Prescriber Restrictions	Atopic Dermatitis-Prescribed by or in consultation with an allergist, immunologist or dermatologist, asthma-prescribed by or in consultation with an allergist, immunologist or pulmonologist. Rhinosinusitis-prescribed by or in consultation with an allergist, immunologist or otolaryngologist.
Coverage Duration	AD-Initial-4 mo, Cont-1 year, asthma/Rhinosinusitis-initial-6 mo, cont 1 year
Other Criteria	Atopic Dermatitis-Initial-meets both a and b: a.has used at least one medium, medium-high, high, and/or super-high-potency prescription topical corticosteroid OR has atopic dermatitis affecting ONLY the face, eyes/eyelids, skin folds, and/or genitalia and has tried tacrolimus ointment AND b.Inadequate efficacy was demonstrated with these previously tried topical prescription therapies, according to the prescribing physician.Continuation-Approve if the pt has responded to Dupixent therapy as determined by the prescribing physician. Asthma-Initial-approve if pt meets the following criteria (i, ii, and iii):i.Pt meets ONE of the following criteria (a or b):a)has a blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin (IL) therapy or Xolair OR b)has oral corticosteroid-dependent asthma, per the prescriber AND ii.has received combination therapy with BOTH of the following (a and b): a)An inhaled corticosteroid (ICS) AND b)At least one additional asthma controller/maintenance medication (NOTE:An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-5 therapy or Xolair used concomitantly with an ICS. Use of a combination inhaler containing both an ICS and a LABA would fulfil the requirement for both criteria a and b) AND iii.asthma is uncontrolled or was uncontrolled prior to starting any anti-IL therapy or Xolair as defined by ONE of the following (a, b, c, d or e): a)experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year OR b)experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department visit in the previous year OR c)has a forced expiratory volume in 1 second (FEV1) less than 80% predicted OR d)has an FEV1/forced vital capacity (FVC) less than 0.80 OR e)The patient's asthma worsens upon tapering of oral corticosteroid therapy. Continuation-Approve if meets the following criteria (i and ii): i.continues to receive therapy with one inhaled corticosteroid (ICS) or one ICS-containing combination inhaler AND ii.has responded to Dupixent therapy as determined by the prescribing physician. Chronic rhinosinusitis with Nasal Polyposis-Initial-pt is currently receiving therapy with an intranasal corticosteroid AND is experiencing significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea, or reduction/loss of smell according to the prescriber AND meets ONE of the following (a or b): a)has received treatment with a systemic corticosteroid within the previous 2 years or has a contraindication to systemic corticosteroid therapy OR b)has had prior surgery for nasal polyps. Continuation-approve if the pt continues to receive therapy with an intranasal corticosteroid AND pt has responded to Dupixent therapy as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	
EMGALITY	

Exclusion Criteria	Combination therapy with Aimovig, Vyepti or Ajovy
Required Medical Info	Diagnosis, number of migraine or cluster headaches per month, prior therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Cluster headache tx-6 months, migraine prevention-1 year
Other Criteria	Migraine headache prevention-Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least two standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and has had inadequate responses to those therapies or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician. Episodic cluster headache treatment-approve if the patient has between one headache every other day and eight headaches per day.
Indications	All FDA-approved Indications.
Off-Label Uses	
ENBREL	
Exclusion Criteria	Concurrent use with biologic therapy or targeted synthetic DMARD
Required Medical Info	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	PP-4 years and older (initial therapy)
Prescriber Restrictions	Initial only-RA/AS/JIA/JRA,prescribed by or in consult w/ rheumatologist. PsA, prescribed by or in consultation w/ rheumatologist or dermatologist. PP, prescribed by or in consult w/ dermatologist.GVHD,prescribed by or in consult w/ oncologist,hematologist,or physician affiliated w/ transplant center.Behcet's disease,prescribed by or in consult w/ rheumatologist,dermatologist,ophthalmologist,gastroenterologist,or neurologist. Uveitis, prescribed by or in consultation with an ophthalmologist.
Coverage Duration	FDA dx-3 mo init,3 yrs cont, Behcet's/uveitis init-3 mo,cont-12 mo.GVHD-1 mo init/3 mo cont.

Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA, approve if the pt has aggressive disease, as determined by the prescriber, or the pt has tried one other agent for this condition (eg, MTX, sulfasalazine, leflunomide, NSAID, biologic DMARD or the pt will be started on Enbrel concurrently with MTX, sulfasalazine, or leflunomide or the pt has an absolute contraindication to MTX (eg, pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias), sulfasalazine, or leflunomide.Plaque psoriasis (PP) initial approve if the patient meets one of the following conditions: 1) patient has tried at least one traditional systemic agent for at least 3 months for plaque psoriasis, unless intolerant (eg, MTX, cyclosporine, Soriatane, oral methoxsalen plus PUVA, (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) the patient has a contraindication to one oral agent for psoriasis such as MTX. GVHD. Tried or currently is receiving with etanercept 1 conventional GVHD tx (high-dose systemic corticosteroid, CSA, tacrolimus, MM, thalidomide, antithymocyte globulin, etc.). Behcet's. Has tried at least 1 conventional tx (eg, systemic corticosteroid, immunosuppressant, interferon alfa, MM, etc) or adalimumab or infliximab. Uveitis-tried one of the following: periocular, intraocular, or systemic corticosteroid, immunosuppressives, Humira or an infliximab product.RA/AS/JIA/PP/PsA Cont - must have a response to tx according to the prescriber. Behcet's, GVHD, Uveitis Cont-if the patient has had a response to tx according to the prescriber. Clinical criteria incorporated into the Enbrel 25 mg quantity limit edit, approve additional quantity (to allow for 50 mg twice weekly dosing) if one of the following is met: 1) Patient has plaque psoriasis, OR 2) Patient has RA/JIA/PsA/AS and is started and stabilized on 50 mg twice weekly dosing, OR 3) Patient has RA and the dose is being increased to 50 mg twice weekly and patient has taken MTX in combination with Enbrel 50 mg once weekly for at least 2 months, unless MTX is contraindicated or intolerant, OR 4) Patient has JIA/PsA/AS and the dose is being increased to 50 mg twice weekly after taking 50 mg once weekly for at least 2 months.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Graft versus host disease (GVHD), Behcet's disease, Uveitis
EPCLUSA	
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin.
Required Medical Info	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	3 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance
EPIDIOLEX	
Exclusion Criteria	
Required Medical Info	Diagnosis, previous therapies
Age Restrictions	Patients 1 year and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
EPOETIN ALFA	
Exclusion Criteria	
Required Medical Info	CRF anemia in patients not on dialysis.Hemoglobin (Hb) of less than 10.0 g/dL for adults or less than or equal to 11 g/dL for children to start.Hb less than or equal to 11.5 g/dL for adults or 12 g/dL or less for children if previously on epoetin alfa, Mircera or Aranesp. Anemia w/myelosuppressive chemotx.pt must be currently receiving myelosuppressive chemo and Hb 10.0 g/dL or less to start.Hb less than or equal to 12.0 g/dL if previously on epoetin alfa or Aranesp.MDS, approve if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start.Previously receiving Aranesp or EA, approve if Hb is 12.0 g/dL or less. Anemia in HIV with zidovudine, Hb is 10.0 g/dL or less or endogenous erythropoietin levels are 500 mU/mL or less at tx start.Previously on EA approve if Hb is 12.0 g/dL or less. Surgical pts to reduce RBC transfusions - Hgb is less than or equal to 13, surgery is elective, nonvascular and non-cardiac and pt is unwilling or unable to donate autologous blood prior to surgery
Age Restrictions	MDS anemia = 18 years of age and older
Prescriber Restrictions	MDS anemia, myelofibrosis- prescribed by or in consultation with, a hematologist or oncologist.
Coverage Duration	Chemo-6m,Transfus-1m, CKD(dialysis)-3yrs, Myelofibrosis-init-3 mo, cont-1 yr, all others-1 yr
Other Criteria	Myelofibrosis-Initial-patient has a Hb less than 10 or serum erythropoietin less than or equal to 500 Mu/mL. Cont-patient has a Hgb less than or equal to 12 and according to the prescriber the patient has had a response defined as Hb greater than or equal to 10 or an increase of greater than or equal to 2 g/dL. For all covered uses, if the request is for Epogen, then the patient is required to try Procrit or Retacrit first.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Anemia due to myelodysplastic syndrome (MDS), Myelofibrosis
ERIVEDGE	

Exclusion Criteria	BCC (La or Met) - must not have had disease progression while on Odomzo.
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Locally advanced basal cell carcinoma (LABCC), approve if 1. the patient's BCC has recurred following surgery or radiation, OR 2. the patient is not a candidate for surgery and radiation therapy. Central nervous system cancer (this includes brain and spinal cord tumors)-approve if the patient has tried at least one chemotherapy agent and according to the prescriber, the patient has a mutation of the sonic hedgehog pathway.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Central nervous System Cancer
ERLEADA	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Prostate cancer-non-metastatic, castration resistant and prostate cancer-metastatic, castration sensitive-approve if the requested medication will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or if the patient has had a bilateral orchiectomy.
Indications	All FDA-approved Indications.
Off-Label Uses	
ESBRIET	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	1 year
Other Criteria	IPF - must have FVC greater than or equal to 40 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.
Indications	All FDA-approved Indications.
Off-Label Uses	

EXJADE/JADENU	
Exclusion Criteria	
Required Medical Info	Serum ferritin level
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	1 year
Other Criteria	Transfusion-related chronic iron overload, initial therapy - approve if the patient is receiving blood transfusions at regular intervals for various conditions (eg, thalassemia syndromes, myelodysplastic syndrome, chronic anemia, sickle cell disease) AND prior to starting therapy, the serum ferritin level is greater than 1,000 mcg/L. Non-transfusion-dependent thalassemia syndromes chronic iron overload, initial therapy - approve if prior to starting therapy the serum ferritin level is greater than 300 mcg/L. Continuation therapy - approve is the patient is benefiting from therapy as confirmed by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	
EYSUVIS	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
FARYDAK	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	

FASENRA	
Exclusion Criteria	Concurrent use with Xolair or another Anti-Interleukin (IL) Monoclonal Antibody
Required Medical Info	Diagnosis, severity of disease, peripheral blood eosinophil count, previous therapies tried and current therapies, FEV1/FVC
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an allergist, immunologist, or pulmonologist
Coverage Duration	Authorization will be for 6 months initial, 12 months continuation.
Other Criteria	Initial - must have peripheral blood eosinophil count of greater than or equal to 150 cells per microliter within the previous 6 weeks (prior to treatment with any anti-interleukin (IL)-5 therapy) AND meet both of the following criteria: 1) Patient has received at least 3 consecutive months of combination therapy with an inhaled corticosteroid AND one of the following: inhaled LABA, inhaled long-acting muscarinic antagonist, Leukotriene receptor antagonist, or Theophylline, AND 2) Patient's asthma is uncontrolled or was uncontrolled prior to starting any anti-IL therapy as defined by ONE of the following: a) patient experienced one or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, OR b) patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year, OR c) patient has a FEV1 less than 80 percent predicted, OR d) Patient has an FEV1/FVC less than 0.80, OR e) Patient's asthma worsens upon tapering of oral corticosteroid therapy. NOTE: An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-5 therapy (e.g., Cinqair, Fasenra, Nucala) used concomitantly with an ICS for at least 3 consecutive months. Continuation - The patient has responded to Fasenra therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations, decreased asthma symptoms, decreased hospitalizations, emergency department (ED)/urgent care, or physician visits due to asthma, decreased requirement for oral corticosteroid therapy) AND patient continues to receive therapy with an inhaled corticosteroid.
Indications	All FDA-approved Indications.
Off-Label Uses	
FERRIPROX	
Exclusion Criteria	
Required Medical Info	Serum ferritin level
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	1 year

Other Criteria	Iron overload, chronic-transfusion related due to thalassemia syndrome or related to sickle cell disease or other anemias-Initial therapy - approve if prior to starting therapy the serum ferritin level was greater than 1,000 mcg/L. Continuation therapy - approve is the patient is benefiting from therapy as confirmed by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	
FINTEPLA	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	2 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with an neurologist (initial therapy)
Coverage Duration	1 year
Other Criteria	Dravet Syndrome-Initial therapy-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs or patient has tried or is concomitantly receiving Epidiolex or Diacomit. Dravet Syndrome-Continuation-approve if the patient is responding to therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	
FIRAZYR	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
Coverage Duration	Authorization will be for 1 year.
Other Criteria	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] - Treatment of Acute Attacks, Initial Therapy-the patient has HAE type I or type II as confirmed by the following diagnostic criteria (i and ii): i. the patient has low levels of functional C1-INH protein (less than 50% of normal) at baseline, as defined by the laboratory reference values AND ii. the patient has lower than normal serum C4 levels at baseline, as defined by the laboratory reference values. Patients who have treated previous acute HAE attacks with icatibant - the patient has treated previous acute HAE type I or type II attacks with icatibant AND according to the prescribing physician, the patient has had a favorable clinical response (e.g., decrease in the duration of HAE attacks, quick onset of symptom relief, complete resolution of symptoms, decrease in HAE acute attack frequency or severity) with icatibant treatment.
Indications	All FDA-approved Indications.

Off-Label Uses	
FIRDAPSE	
Exclusion Criteria	History of seizures (initial therapy)
Required Medical Info	Diagnosis, seizure history, lab and test results
Age Restrictions	18 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a neuromuscular specialist (initial therapy)
Coverage Duration	Initial-3 months, Cont-1 year
Other Criteria	Initial therapy-Diagnosis confirmed by at least one electrodiagnostic study (e.g., repetitive nerve stimulation) OR anti-P/Q-type voltage-gated calcium channels (VGCC) antibody testing according to the prescribing physician. Continuation-patient continues to derive benefit (e.g., improved muscle strength, improvements in mobility) from Firdapse, according to the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	
FOTIVDA	
Exclusion Criteria	
Required Medical Info	Diagnosis, other therapies
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years
Other Criteria	Renal Cell Carcinoma (RCC)-approve if the patient has relapsed or Stage IV disease and has tried at least two other systemic regimens. Note: Examples of systemic regimens for renal cell carcinoma include axitinib tablets, axitinib + pembrolizumab injection, cabozantinib tablets, cabozantinib + nivolumab injection, sunitinib malate capsules, pazopanib tablets, sorafenib tablets, and lenvatinib capsules + everolimus.
Indications	All FDA-approved Indications.
Off-Label Uses	
GATTEX	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	1 year and older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist (initial and continuation)
Coverage Duration	1 year

Other Criteria	Initial-approve if the patient is currently receiving parenteral nutrition on 3 or more days per week or according to the prescriber, the patient is unable to receive adequate total parenteral nutrition required for caloric needs. Continuation-approve if the patient has experienced at least a 20 percent decrease from baseline in the weekly volume of parenteral nutrition.
Indications	All FDA-approved Indications.
Off-Label Uses	
GAVRETO	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	NSCLC-18 years and older, MTC/thyroid cancer-12 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	NSCLC-approve if the patient has metastatic disease and rearranged during transfection (RET) fusion-positive disease detected by an Food and Drug Administration (FDA) approved test. Medullary thyroid cancer (MTC)-approve if the patient has advanced or metastatic rearranged during transfection (RET)-mutant disease and the disease requires treatment with systemic therapy. Thyroid cancer (other than MTC)-approve if the patient has advanced or metatstatic rearranged during transfection (RET) fusion-positive disease, the disease is radioactive iodine-refractory AND the disease requires treatment with systemic therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	
GILENYA	
Exclusion Criteria	Concurrent use of Gilenya with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Info	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
GILOTRIF	
Exclusion Criteria	
Required Medical Info	For NSCLC - EGFR exon deletions or mutations, or if NSCLC is squamous cell type

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	NSCLC EGFR pos - For the treatment of metastatic non small cell lung cancer (NSCLC) must be used in tumors with non-resistant EGFR mutation positive NSCLC as detected by an approved test. NSCLC metastatic squamous cell must have disease progression with first line treatment with platinum based chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	
GLUCAGON-LIKE PEPTIDE-1 AGONISTS	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
GONADOTROPIN-RELEASING HORMONE AGONISTS - INJECTABLE LONG ACTING	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	For the treatment of cancer diagnosis must be prescribed by or in consultation with an oncologist.
Coverage Duration	For abnormal uterine bleeding/uterine leiomyomata approve 6 months/all other dx 12 mo
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Ovarian cancer, breast cancer, prophylaxis or treatment of uterine bleeding in patients with hematologic malignancy or undergoing cancer treatment or prior to bone marrow/stem cell transplantation, head and neck cancer-salivary gland tumors
GRALISE/HORIZANT/LYRICA CR	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	

Coverage Duration	Authorization will be for 12 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off-Label Uses	
GROWTH HORMONES	
Exclusion Criteria	
Required Medical Info	GHD in Children/Adolescents. Pt meets one of the following-1-had 2 GH stim tests with the following-levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon and both are inadequate as defined by a peak GH response which is below the normal reference range of the testing laboratory OR had at least 1 GH test and results show inadequate response and has at least one risk factor for GHD (e.g., ht for age curve deviated down across 2 major height percentiles [e.g., from above the 25 percentile to below the 10 percentile], growth rate is less than the expected normal growth rate based on age and gender, low IGF-1 and/or IGFBP-3 levels). 2.brain radiation or tumor resection and pt has 1 GH stim test and results is inadequate response or has def in at least 1 other pituitary hormone (that is, ACTH, TSH, gonadotropin deficiency [LH and/or FSH] are counted as 1 def), or prolactin).3. congenital hypopituitarism and has one GH stim test with inadequate response OR def in at least one other pituitary hormone and/or the patient has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk 4.pt has panhypopituitarism and has pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, or ectopic posterior pituitary bright spot on MRI or CT or pt has 3 or more pituitary hormone deficiencies or pt has had one GH test and results were inadequate 5.pt had a hypophysectomy. Cont-pt responding to therapy
Age Restrictions	ISS 5 y/o or older, SGA 2 y/o or older, SBS 18 y/o or older
Prescriber Restrictions	GHD (Initial tx children or adolescents w/o hypophysectomy), GHD adults or transitional adolescents, Noonan (initial), Prader Willi (initial for child/adult and cont tx in adults), SHOX (initial), SGA (initial) - prescribed by or in consultation with an endocrinologist. CKD (initial) endocrinologist or nephrologist.
Coverage Duration	ISS - 6 mos initial, 12 months cont tx, SBS 1 month, others 12 mos

Other Criteria	GHD initial in adults and adolescents 1. endocrine must certify not being prescribed for anti-aging or to enhance athletic performance, 2. has either childhood onset or adult onset resulting from GHD alone, multiple hormone deficiency from pituitary dx, hypothalamic dz, pituitary surgery, cranial radiation tx, tumor treatment, TBI or subarachnoid hemorrhage, AND 3. meets one of the following - A. has known mutations, embryonic lesions, congenital or genetic defects or structural hypothalamic pituitary defects, B. 3 or more pituitary hormone def (ACTH, TSH, LH/FSH, or prolactin, IGF1 less than 84 mcg/L (Esoterix RIA), AND other causes of low serum IGF-1 have been excluded, C. Neg response to ONE preferred GH stim test (insulin peak response less than or equal to 5 mcg/L, Glucagon peak less than or equal to 3 mcg/L (BMI is less than or equal to 25), less than or equal to 3 and BMI is greater than or equal to 25 and less than or equal to 30 with a high pretest probability of GH deficiency, less than or equal to 1 and BMI is greater than or equal to 25 and less than or equal to 30 with a low pretest probability of GH deficiency or less than or equal to 1 mcg/L (BMI is greater than 30), if insulin and glucagon contraindicated then Arginine alone test with peak of less than or equal to 0.4 mcg/L, or Macrilen peak less than 2.8 ng/ml AND BMI is less than or equal to 40 AND if a transitional adolescent must be off tx for at least one month before retesting. Cont tx - endocrine must certify not being prescribed for anti-aging or to enhance athletic performance. ISS initial - baseline ht less than the 1.2 percentile or a standard deviation score (SDS) less than -2.25 for age and gender, open epiphyses, does not have CDGP and height velocity is either growth rate (GR) is a. less than 4 cm/yr for pts greater than or equal to 5 or b. growth velocity is less than 10th percentile for age/gender. Cont tx - prescriber confirms response to therapy. CKD initial - CKD defined by abnormal CrCl. Noonan initial - baseline height less than 5th percentile. PW cont tx in adults or adolescents who don't meet child requir - physician certifies not being used for anti-aging or to enhance athletic performance. SHOX initial - SHOX def by chromo analysis, open epiphyses, height less than 3rd percentile for age/gender. SGA initial -baseline ht less than 5th percentile for age/gender and born SGA (birth weight/length that is more than 2 SD below mean for gestational age/gender and didn't have sufficient catch up growth by 2-4 y/o). Cont tx - prescriber confirms response to therapy.Cont Tx for CKD, Noonan, PW in child/adolescents, SHOX, and TS - prescriber confirms response to therapy. SBS initial pt receiving specialized nutritional support. Cont tx - 2nd course if pt responded to tx with a decrease in the requirement for specialized nutritional support.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	CKD, SHOX, SBS
HARVONI	
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin
Required Medical Info	
Age Restrictions	3 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD

Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance
HETLIOZ	
Exclusion Criteria	
Required Medical Info	Non-24-patient is totally blind with no perception of light
Age Restrictions	Non-24-18 years or older, SMS-16 years and older
Prescriber Restrictions	prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of sleep disorders
Coverage Duration	6 mos initial, 12 mos cont
Other Criteria	Initial - dx of Non-24 is confirmed by either assessment of one physiologic circadian phase marker (e.g., measurement of urinary melatonin levels, dim light melatonin onset, assessment of core body temperature), or if assessment of physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy performed plus evaluation of sleep logs recorded. Cont - Approve if pt has achieved adequate results with Hetlioz therapy according to the prescribing physician (e.g., entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep). Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)-approve.
Indications	All FDA-approved Indications.
Off-Label Uses	
HIGH RISK MEDICATIONS - BENZODIAZEPINES	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	
Coverage Duration	Procedure-related sedation = 1mo. All other conditions = 12 months.
Other Criteria	All medically accepted indications other than insomnia, authorize use. Insomnia, may approve lorazepam if the patient has had a trial with two of the following: ramelteon, doxepin 3mg or 6 mg, eszopiclone, zolpidem, or zaleplon. Prior to approval, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	
HIGH RISK MEDICATIONS - BENZTROPINE	

Exclusion Criteria	
Required Medical Info	
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For all medically-accepted indications, approve if the prescriber confirms he/she has assessed risk versus benefit in prescribing benztropine for the patient and he/she would still like to initiate/continue therapy
Indications	All Medically-accepted Indications.
Off-Label Uses	
HIGH RISK MEDICATIONS - CYCLOBENZAPRINE	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Patients aged less than 65 years, approve.
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	The physician has assessed risk versus benefit in using this High Risk Medication (HRM) in this patient and has confirmed that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	
HIGH RISK MEDICATIONS - FIRST GENERATION ANTIHISTAMINES	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For hydroxyzine hydrochloride, authorize use without a previous drug trial for all FDA-approved indications other than anxiety. Approve hydroxyzine hydrochloride if the patient has tried at least two other FDA-approved products for the management of anxiety. Prior to approval of promethazine and hydroxyzine, approve if the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	
HIGH RISK MEDICATIONS - PHENOBARBITAL	

Exclusion Criteria	Coverage is not provided for use in sedation/insomnia.
Required Medical Info	
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For the treatment of seizures, approve only if the patient is currently taking phenobarbital.
Indications	All Medically-accepted Indications.
Off-Label Uses	
HIGH RISK MEDICATIONS- ESTROGENS	
Exclusion Criteria	
Required Medical Info	Previous medication use
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months
Other Criteria	For the treatment of Vulvar Vaginal Atrophy, approve if the patient has had a trial of one of the following for vulvar vaginal atrophy (brand or generic): Estradiol Vaginal Cream, Estring,or estradiol valerate. For prophylaxis of Postmenopausal Osteoporosis, approve if the patient has had a trial of one of the following (brand or generic): alendronate, ibandronate, risidronate or Raloxifene. The physician has assessed risk versus benefit in using this High Risk medication (HRM) in this patient and has confirmed that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	
HUMIRA	
Exclusion Criteria	Concurrent use with another biologic DMARD or targeted synthetic DMARD.
Required Medical Info	Diagnosis, concurrent medications, previous therapies tried
Age Restrictions	Crohn's disease (CD), 6 or older (initial therapy only). Ulcerative colitis (UC), 5 or older (initial therapy only)
Prescriber Restrictions	Initial therapy only for all dx-RA/JIA/JRA/Ankylosing spondylitis, prescribed by or in consultation with rheumatologist. Psoriatic arthritis (PsA), prescribed by or in consultation with a rheumatologist or dermatologist. Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist. UC/ CD, prescribed by or in consultation with a gastroenterologist. HS - dermatologist.UV-ophthalmologist
Coverage Duration	initial 3 mo, cont tx 3 years.

Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA initial. Tried another agent (e.g MTX, sulfasalazine, leflunomide, NSAID, or biologic DMARD (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial. Tried corticosteroids (CSs) or if CSs are contraindicated or if pt currently on CSs or patient has tried one other agent for CD (eg, azathioprine, 6-mercaptopurine, MTX, certolizumab, infliximab, ustekinumab, or vedolizumab) OR pt had ilecolonic resection OR enterocutaneous (perianal or abdominal) or rectovaginal fistulas. UC initial. Pt has tried a systemic therapy (eg, 6-mercaptopurine, azathioprine, CSA, tacrolimus, infliximab, golimumab SC, or a corticosteroid such as prednisone or methylprednisolone) or the pt has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine (Rowasa) enema. FDA approve indications cont tx - must respond to tx as determined by prescriber. HS - tried ONE other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin). Clinical criteria incorporated into the Humira 40 mg quantity limit edit allow for approval of additional quantities to accommodate induction dosing. The allowable quantity is dependent upon the induction dosing regimen for the applicable FDA-labeled indications as outlined in product labeling.
Indications	All FDA-approved Indications.
Off-Label Uses	
IBRANCE	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years

Other Criteria	Breast cancer - approve advanced (metastatic) hormone receptor positive (HR+) [i.e., estrogen receptor positive- (ER+) and/or progesterone receptor positive (PR+)] disease, and HER2-negative breast cancer when the pt meets ONE of the following 1. Pt is postmenopausal and Ibrance will be used in combination with anastrozole, exemestane, or letrozole 2, pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with GnRH agonists, or has had surgical bilateral oophorectomy, or ovarian irradiation AND meets one of the following conditions: Ibrance will be used in combination with anastrozole, exemestane, or letrozole Ibrance will be used in combination with fulvestrant 3. pt is a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) who is receiving GnRH analog AND Ibrance with be used in combination with anastrozole, exemestane or letrozole or Ibrance will be used in combination with fulvestrant 4. Pt is postmenopausal and Ibrance will be used in combination with fulvestrant
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Liposarcoma
ICLUSIG	
Exclusion Criteria	
Required Medical Info	Diagnosis the Philadelphia chromosome (Ph) status of the leukemia must be reported. T315I status
Age Restrictions	CML/ALL - Adults
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	CML Ph+, T315I-positive or has tried TWO other TKIs indicated for use in Philadelphia chromosome positive CML (e.g., Gleevec, Sprycel, Tasigna). ALL Ph+, T315I-posistive or has tried TWO other TKIs indicated for use in Ph+ ALL (e.g. Gleevec, Sprycel.)
Indications	All FDA-approved Indications.
Off-Label Uses	
IDHIFA	
Exclusion Criteria	
Required Medical Info	IDH2-mutation status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	AML - approve if the patient is IDH2-mutation status positive as detected by an approved test
Indications	All FDA-approved Indications.
Off-Label Uses	
IMATINIB	

Exclusion Criteria	
Required Medical Info	Diagnosis. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	For ALL/CML, must have Ph-positive for approval of imatinib. AIDS related Kaposi's Sarcoma-approve if the patient has tried at least one regimen AND has relapsed or refractory disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chordoma, advanced or unresectable fibromatosis (desmoid tumors), cKit positive advanced/recurrent or metastatic melanoma, AIDS Related Kaposi's Sarcoma and pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor.
IMBRUVICA	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	GVHD-1 year, all others-3 years
Other Criteria	Marginal Zone Lymphoma - Approve. GVHD-Approve if the patient has tried one conventional systemic treatment for graft versus host disease (e.g., corticosteroids [methylprednisolone, prednisone], cyclosporine, tacrolimus, mycophenolate mofetil, imatinib, Jakafi). B-cell lymphoma-approve if the patient is using Imbruvica as second-line or subsequent therapy according to the prescribing physician. Central nervous system Lymphoma (primary)/Hairy Cell Leukemia-approve if relapsed or refractory.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Central Nervous System Lymphoma (Primary), Hairy Cell Leukemia, B-Cell Lymphoma (e.g., follicular lymphoma, gastric MALT lymphoma, nongastric MALT lymphoma, AIDS related, post-transplant lymphoproliferative disorders).
IMPAVIDO	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an infectious diseases specialist
Coverage Duration	1 month

Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
INJECTABLE TESTOSTERONE PRODUCTS	
Exclusion Criteria	
Required Medical Info	Diagnosis, lab results
Age Restrictions	Delayed puberty or induction of puberty in males-14 years and older
Prescriber Restrictions	
Coverage Duration	Delayed puberty or induction of puberty in males-6 months, all others-12 months
Other Criteria	Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. Hypogonadism (primary or secondary) in males - continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) AND 2) patient had at least one pre-treatment serum testosterone level that was low. Delayed puberty or induction of puberty in males - Approve testosterone enanthate. Breast cancer in females - Approve testosterone enanthate. Male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression. Female is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression
Indications	All FDA-approved Indications.
Off-Label Uses	
INLYTA	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Advanced Renal cell carcinoma-approve. Differentiated thyroid cancer, approve if patient is refractory to radioactive iodine therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma

INQOVI	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
INREBIC	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF-approve if the patient has intermediate-2 or high-risk disease.
Indications	All FDA-approved Indications.
Off-Label Uses	
IRESSA	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Metastatic NSCLC - The patient has epidermal growth factor receptor (EGFR) exon 19 deletions OR has exon 21 (L858R) substitution mutations as detected by an FDA-approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	
IVIG	
Exclusion Criteria	
Required Medical Info	

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Part B versus D determination per CMS guidance to establish if drug used for PID in pt's home.
Indications	All Medically-accepted Indications.
Off-Label Uses	
JAKAFI	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	ALL-less than 21 years of age
Prescriber Restrictions	
Coverage Duration	GVHD/ALL-1 year, all others-3 years.
Other Criteria	For polycythemia vera patients must have tried hydroxyurea. ALL-approve if the mutation/pathway is Janus associated kinase (JAK)-related. GVHD, chronic-approve if the patient has tried one conventional systemic treatment for graft versus host disease. GVHD, acute-approve if the patient has tried one systemic corticosteroid. Atypical chronic myeloid leukemia-approve if the patient has a CSF3R mutation or a janus associated kinase mutation. Chronic monomyelocytic leukemia-2 (CMML-2)-approve if the patient is also receiving a hypomethylating agent.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Acute lymphoblastic leukemia, graft versus host disease, chronic, atypical chronic myeloid leukemia, chronic monomyelocytic leukemia-2 (CMML-2)
JUXTAPID	
Exclusion Criteria	Combination use with Kynamro, Praluent, or Repatha.
Required Medical Info	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, an endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	12 months

Other Criteria	Patient must meet ALL of the following criteria: 1) Patient has had genetic confirmation of two mutant alleles at the LDL receptor, apolipoprotein B APOB, PCSK9, or LDLRAP1 gene locus OR the patient has an untreated LDL-C level greater than 500 mg/dL (prior to treatment with antihyperlipidemic agents) OR the patient has a treated LDL-C level greater than or equal to 300 mg/dL (after treatment with antihyperlipidemic agents but prior to agents such as Repatha) OR the patient has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND 2) Patient has tried Repatha and had an inadequate response according to the prescribing physician OR the patient is known to have two LDL-receptor negative alleles, AND 3) Patient has tried one high-intensity statin therapy (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than 20 mg daily [as a single-entity or as a combination product]) for greater than or equal to 8 continuous weeks and the LDL-C level remains greater than or equal to 70 mg/dL OR the patient has been determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or patient experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation.
Indications	All FDA-approved Indications.
Off-Label Uses	
KALYDECO	
Exclusion Criteria	Combination use with Orkambi, Trikafta or Symdeko
Required Medical Info	
Age Restrictions	4 months of age and older
Prescriber Restrictions	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	1 year
Other Criteria	CF - must have one mutation in the CFTR gene that is responsive to the requested medication.
Indications	All FDA-approved Indications.
Off-Label Uses	
KESIMPTA	
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Info	Relapsing form of Multiple Sclerosis (MS), to include, clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis
Coverage Duration	Authorization will be for 1 year
Other Criteria	

Indications	All FDA-approved Indications.
Off-Label Uses	
KISQALI	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Breast cancer - approve advanced or metastatic hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)]disease, and HER2-negative breast cancer when the pt meets ONE of the following 1. Pt is postmenopausal and Kisqali will be used in combination with anastrozole, exemestane, or letrozole 2. pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with GnRH agonist, or has had surgical bilateral oophorectomy, or ovarian irradiation AND Kisqali will be used in combination with anastrozole, exemestane, or letrozole 3. pt is a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) who is receiving GnRH analog AND Kisqali with be used in combination with anastrozole, exemestane or letrozole. 4. Patient is postmenopausal, pre/perimenopausal or a man, and Kisqali (not Co-Pack) will be used in combination with fulvestrant. If the request is for Kisqali Femara, patients do not need to use in combination with anastrozole, exemestane, or letrozole. Patients must have a trial of Ibrance prior to approval of Kisqali/Kisqali Femara Co-Pack unless the patient meets one of the following-a) Patient has been taking Kisqali or Kisqali Femara Co-Pack and is continuing therapy OR b) Patient is pre/perimenopausal and will be using Kisqali or Kisqali Femara Co-Pack in combination with an aromatase inhibitor as initial endocrine-based therapy OR c) Kisqali will be used in combination with fulvestrant in postmenopausal female or male patients as initial endocrine-based therapy
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Men with breast cancer
KORLYM	
Exclusion Criteria	
Required Medical Info	Diagnosis, prior surgeries
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome
Coverage Duration	Endogenous Cushing's Synd-1 year. Patients awaiting surgery or response after radiotherapy-4 months

Other Criteria	Endogenous Cushing's Syndrome-Approve if, according to the prescribing physician, the patient is not a candidate for surgery or surgery has not been curative AND if Korlym is being used to control hyperglycemia secondary to hypercortisolism in patients who have type 2 diabetes mellitus or glucose intolerance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Endogenous Cushing's Syndrome, awaiting surgery. Patients with Endogenous Cushing's syndrome, awaiting a response after radiotherapy
KUVAN	
Exclusion Criteria	Concurrent use with Palynziq (continuation only)
Required Medical Info	Diagnosis, Phe concentration
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases (initial therapy)
Coverage Duration	Initial-12 weeks, Continuation-1 year
Other Criteria	Initial - approve. Continuation - approve if the patient has had a clinical response (e.g., cognitive and/or behavioral improvements) as determined by the prescribing physician OR patient had a 20% or greater reduction in blood Phe concentration from baseline OR treatment with sapropterin has resulted in an increase in dietary phenylalanine tolerance.
Indications	All FDA-approved Indications.
Off-Label Uses	
KYNMOBI	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Parkinson's Disease-Approve if the patient is experiencing off episodes, such as muscle stiffness, slow movements or difficulty starting movements, is currently receiving carbidopa/levodopa and has previously tried one other treatment for off episodes.
Indications	All FDA-approved Indications.
Off-Label Uses	
LENVIMA	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	

Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	DTC - must be refractory to radioactive iodine treatment for approval. RCC (clear cell or non-clear cell) - approve if the pt meets ALL of the following criteria: 1) pt has relapsed or stage IV disease, 2)if disease is predominant clear-cell histology then the pt has tried one antiangiogenic therapy (eg, Inlyta, Votrient, Sutent, Cabometyx) AND 3) Lenvima will be used in combination with everolimus (Afinitor). MTC-approve if the patient has tried Caprelsa or Cometriq. Anaplastic thyroid cancer-approve if the disease does not have a curative option. Endometrial Carcinoma-Approve if the patient meets the following criteria (A, B, C, and D): A) The patient has advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) AND B) The medication is used in combination with Keytruda (pembrolizumab for intravenous injection) AND C)the disease has progressed on at least one prior systemic therapy AND D) The patient is not a candidate for curative surgery or radiation.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Medullary Thyroid Carcinoma (MTC) and anaplastic thyroid carcinoma.
LETAIRIS/TRACLEER	
Exclusion Criteria	
Required Medical Info	Pulmonary arterial hypertension (PAH) WHO Group 1, results of right heart cath
Age Restrictions	
Prescriber Restrictions	For treatment of pulmonary arterial hypertension, ambrisentan or bosentan must be prescribed by or in consultation with a cardiologist or a pulmonologist. CTEPH - prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	Authorization will be for 1 year.
Other Criteria	CTEPH - pt must have tried Adempas, has a contraindication to Adempas, or is currently receiving bosentan for CTEPH. Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chronic thromboembolic pulmonary hypertension (CTEPH) (bosentan)
LEUKINE	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	Neuroblastoma-less than 18 years of age

Prescriber Restrictions	AML if prescribed by or in consultation with an oncologist or hematologist, PBPC/BMT - prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in transplantation, Radiation syndrome-prescribed by or in consultation with physician with expertise in treating acute radiation syndrome.Neuroblastoma-prescribed by or in consultation with an oncologist.
Coverage Duration	Radiation Syndrome/BMT - 1 mo, AML/Neuroblastoma-6 months, PBPC-14 days
Other Criteria	Neuroblastoma-approve if the patient is receiving Leukine in a regimen with dinutuximab.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Neuroblastoma
LIDOCAINE PATCH	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Diabetic neuropathic pain, chronic back pain
LONG ACTING OPIOIDS	
Exclusion Criteria	Acute (ie, non-chronic) pain
Required Medical Info	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For pain severe enough to require daily, around-the-clock, long-term opioid treatment, approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Patients with cancer, sickle cell disease, in hospice or who reside in a long term care facility are not required to meet above criteria. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.

Indications	All FDA-approved Indications.
Off-Label Uses	
LONSURF	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Gastric or Gastroesophageal Junction Adenocarcinoma-approve if the patient has been previously treated with at least two chemotherapy regimens for gastric or gastroesophageal junction adenocarcinoma.
Indications	All FDA-approved Indications.
Off-Label Uses	
LORBRENA	
Exclusion Criteria	
Required Medical Info	Diagnosis, ALK status, ROS1 status, previous therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	NSCLC - Approve if the patient has ALK-positive metastatic NSCLC. NSCLC-ROS1 Rearrangement-Positive-approve if the patient has tried one of crizotinib, entrectinib or ceritinib.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Non-small cell lung cancer (NSCLC)-ROS1 Rearrangement-Positive
LYNPARZA	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years

Other Criteria	Ovarian Cancer - Treatment-initial-Approve if the patient meets the following criteria (i and ii): i. patient has a germline BRCA-mutation as confirmed by an approved test AND per product labeling the patient has progressed on three or more prior lines of chemotherapy. Continuation-approve if the patient has a BRCA mutation (germline) as confirmed by an approved test. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer - Maintenance monotherapy-Approve if the patient meets one of the following criteria (A or B): A) patient meets both of the following criteria for first-line maintenance therapy (i and ii): i. patient has a germline or somatic BRCA mutation-positive disease as confirmed by an approved test AND ii. The patient is in complete or partial response to first-line platinum-based chemotherapy regimen (e.g., carboplatin with paclitaxel, carboplatin with doxorubicin, docetaxel with carboplatin) OR B)The patient is in complete or partial response after at least two platinum-based chemotherapy regimens (e.g., carboplatin with gemcitabine, carboplatin with paclitaxel, cisplatin with gemcitabine). Ovarian, fallopian tube, or primary peritoneal cancer-maintenance, combo tx-approve if Lynparza is used in combo with bevacizumab, pt has homologous recombination deficiency (HRD)-positive disease, as confirmed by an approved test and pt is in complete or partial response to first-line platinum-based chemotherapy regimen. Breast Cancer-Approve if the patient meets the following criteria (A, B, and C)-A. The patient has metastatic, germline BRCA mutation-positive breast cancer AND B. The patient meets ONE of the following criteria (i or ii)- i. The patient meets BOTH of the following criteria (a and b)-a) The patient has hormone receptor positive (HR+) [i.e., estrogen receptor positive ER+ and/or progesterone receptor positive PR+] disease AND b) The patient meets ONE of the following criteria (1 or 2)-1-The patient has been treated with prior endocrine therapy OR-2 The patient is considered inappropriate for endocrine therapy OR ii. Patient has triple negative disease (i.e., ER-negative, PR-negative, and HER2-negative) AND C. The patient has been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting. Pancreatic Cancer-maintenance therapy-approve if the patient has a germline BRCA mutation-positive metastatic disease and the disease has not progressed on at least 16 weeks of treatment with a first-line platinum-based chemotherapy regimen. Prostate cancer-castration resistant-approve if pt has metastatic disease, Lynparza is used concurrently with a GnRH analog or pt has had a bilateral orchiectomy, pt has germline or somatic homologous recombination repair (HRR) gene-mutated disease, as confirmed by an approved test, pt does not have a PPP2R2A mutation and pt has been previously treated with abiraterone or Xtandi.
Indications	All FDA-approved Indications.
Off-Label Uses	
MEGACE	
Exclusion Criteria	Coverage is not provided for weight gain for cosmetic reasons.
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	

Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off-Label Uses	
MEKINIST	
Exclusion Criteria	
Required Medical Info	Diagnosis for which Mekinist is being used. For melanoma, thyroid cancer and NSCLC must have documentation of BRAF V600 mutations
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Melanoma must be used in patients with BRAF V600 mutation, and patient has unresectable, advanced (including Stage III or Stage IV disease), or metastatic melanoma. Note-This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery.For NSCLC requires BRAF V600E Mutation and use in combination with Tafinlar. Thyroid cancer, anaplastic-patient has locally advanced or metastatic anaplastic disease AND Mekinist will be taken in combination with Tafinlar, unless intolerant AND the patient has BRAF V600-positive disease. Ovarian/fallopian tube/primary peritoneal cancer-approve if the patient has recurrent disease and the medication is used for low-grade serous carcinoma.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Ovarian/Fallopian Tube/Primary Peritoneal Cancer
MEKTOVI	
Exclusion Criteria	
Required Medical Info	Diagnosis, BRAF V600 status, concomitant medications
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation AND Mektovi will be used in combination with Braftovi. Colon or Rectal cancer-approve if the patient meets the following (A, B, and C): A) The patient has BRAF V600E mutation-positive disease AND B) The patient has previously received a chemotherapy regimen for colon or rectal cancer AND C) The agent is prescribed as part of a combination regimen for colon or rectal cancer.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Colon or rectal cancer

MEMANTINE	
Exclusion Criteria	
Required Medical Info	Indication for which memantine is being prescribed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with mild to moderate vascular dementia.
MIGLUSTAT	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of Gaucher disease or related disorders
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
MULPLETA	
Exclusion Criteria	
Required Medical Info	Diagnosis, platelet count, date of procedure
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	7 days
Other Criteria	Approve if the patient has a current platelet count less than 50 x 109/L AND the patient is scheduled to undergo a procedure within 8 to 14 days after starting Mulpleta therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	
MYALEPT	
Exclusion Criteria	
Required Medical Info	

Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist or a geneticist physician specialist
Coverage Duration	Authorization will be for 3 years.
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
NATPARA	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	1 year
Other Criteria	Chronic hypoparathyroidism, initial therapy - approve if before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician. Chronic hypoparathyroidism, continuing therapy - approve if during Natpara therapy, the patient's 25-hydroxyvitamin D stores are sufficient per the prescribing physician, AND the patient is responding to Natpara therapy, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	
NAYZILAM	
Exclusion Criteria	
Required Medical Info	Diagnosis, other medications used at the same time
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
Indications	All FDA-approved Indications.
Off-Label Uses	
NERLYNX	
Exclusion Criteria	
Required Medical Info	Stage of cancer, HER2 status, previous or current medications tried
Age Restrictions	

Prescriber Restrictions	
Coverage Duration	Adjuvant tx-Approve for 1 year (total), advanced or metastatic disease-3yrs
Other Criteria	Breast cancer, adjuvant therapy - approve if the patient meets all of the following criteria:Patient has HER2-positive breast cancer AND Patient has completed one year of adjuvant therapy with trastuzumab OR could not tolerate one year of therapy. Breast cancer, advanced or metastatic disease-approve if the patient has HER-2 positive breast cancer, Nerlynx will be used in combination with capecitabine and the patient has tried at least two prior anti-HER2 based regimens in the metastatic setting.
Indications	All FDA-approved Indications.
Off-Label Uses	
NEXAVAR	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Osteosarcoma, approve if the patient has tried standard chemotherapy and have relapsed/refractory or metastatic disease. GIST, approve if the patient has tried TWO of the following: imatinib mesylate (Gleevec), sunitinib (Sutent), or regorafenib (Stivarga). Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma (DTC), approve if the patient is refractory to radioactive iodine treatment. Medullary thyroid carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). AML - Approve if disease is FLT3-ITD mutation positive as detected by an approved test. Renal cell carcinoma (RCC)-approve if the patient has relapsed or Stage IV clear cell histology and the patient has tried at least one prior systemic therapy (e.g., Inlyta, Votrient, Sutent Cabometyx). Ovarian, fallopian tube, primary peritoneal cancer-approve if the patient has platinum resistant disease and Nexavar is used in combination with topotecan.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Osteosarcoma, angiosarcoma, desmoids tumors (aggressive fibromatosis), gastrointestinal stromal tumors (GIST), medullary thyroid carcinoma, Acute Myeloid Leukemia, Chordoma with recurrent disease, solitary fibrous tumor and hemangiopericytoma, ovarian, fallopian tube, primary peritoneal cancer
NEXLETOL	
Exclusion Criteria	
Required Medical Info	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	18 years and older
Prescriber Restrictions	

Coverage Duration	Authorization will be for 1 year
Other Criteria	Heterozygous Familial Hypercholesterolemia (HeFH) -approve if pt meets one of the following: patient has an untreated low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL (prior to treatment with antihyperlipidemic agents) OR patient has genetic confirmation of HeFH by mutations in the low-density lipoprotein receptor, apolipoprotein B, proprotein convertase subtilisin kexin type 9 or low-density lipoprotein receptor adaptor protein 1 gene OR patient has been diagnosed with HeFH meeting one of the following diagnostic criteria thresholds (a or b): a) The prescriber used the Dutch Lipid Network criteria and the patient has a score greater than 5 OR b) The prescriber used the Simon Broome criteria and the patient met the threshold for definite or possible familial hypercholesterolemia OR patient has clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma) AND Pt tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) AND ezetimibe concomitantly for greater than or equal to 8 continuous weeks and LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation. Atherosclerotic Cardiovascular Disease (ASCVD) -approve if pt meets all of the following: Pt has one of the following conditions: prior MI, history of ACS, diagnosis of angina (stable or unstable), history of stroke or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND Pt tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) AND ezetimibe concomitantly for greater than or equal to 8 continuous weeks and LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation
Indications	All FDA-approved Indications.
Off-Label Uses	
NEXLIZET	
Exclusion Criteria	
Required Medical Info	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 1 year

Other Criteria	Heterozygous Familial Hypercholesterolemia (HeFH) -approve if pt meets one of the following: has an untreated low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL (prior to treatment with antihyperlipidemic agents) OR has genetic confirmation of HeFH by mutations in the low-density lipoprotein receptor, apolipoprotein B, proprotein convertase subtilisin kexin type 9 or low-density lipoprotein receptor adaptor protein 1 gene OR has been diagnosed with HeFH meeting one of the following diagnostic criteria thresholds (a or b): a) The prescriber used the Dutch Lipid Network criteria and the patient has a score greater than 5 OR b) The prescriber used the Simon Broome criteria and the patient met the threshold for definite or possible familial hypercholesterolemia OR patient has clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma) AND Pt tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) for greater than or equal to 8 continuous weeks and LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation. Atherosclerotic Cardiovascular Disease (ASCVD) -approve if pt meets all of the following: Pt has one of the following conditions: prior MI, history of ACS, diagnosis of angina (stable or unstable), history of stroke or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND Pt tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) for greater than or equal to 8 continuous weeks and LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation.
Indications	All FDA-approved Indications.
Off-Label Uses	
NILUTAMIDE	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Prostate cancer-approve if nilutamide is used concurrently with a luteinizing hormone-releasing hormone (LHRH) agonist.
Indications	All FDA-approved Indications.

Off-Label Uses	
NINLARO	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	MM - be used in combination with Revlimid and dexamethasone OR pt had received at least ONE previous therapy for multiple myeloma (e.g., Thalomid, Revlimid, Pomalyst, Alkeran, dexamethasone, prednisone) OR the agent will be used following autologous stem cell transplantation (ASCT). Systemic light chain amyloidosis-approve if the patient has tried at least one other regimen for this condition. Waldenstrom Macroglobulinemia/lymphoplasmacytic lymphoma-approve if used in combination with a rituximab product and dexamethasone (applies only to beneficiaries enrolled in an MA-PD plan).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with systemic light chain amyloidosis, Waldenstrom Macroglobulinemia/lymphoplasmacytic lymphoma
NITYR/ORFADIN	
Exclusion Criteria	Concomitant therapy with nitisinone products
Required Medical Info	Diagnosis, genetic tests and lab results
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
Coverage Duration	1 year
Other Criteria	Hereditary Tyrosinemia, Type 1-approve if the prescriber confirms the diagnosis was confirmed by genetic testing confirming a mutation of the FAH gene OR elevated serum levels of alpha-fetoprotein (AFP) and succinylacetone.
Indications	All FDA-approved Indications.
Off-Label Uses	
NIVESTYM	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	

Prescriber Restrictions	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. Radiation-expertise in acute radiation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
Coverage Duration	chem/SCN/AML-6 mo.HIV/AIDS-4 mo.MDS/BMT-3 mo.PBPC,Drug induce A/N,AA,ALL-3 mo. Radi-1 mo.other=12mo
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, or HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, filgrastim products, pegfilgrastim products) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL). Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome).
NON-INJECTABLE TESTOSTERONE PRODUCTS	
Exclusion Criteria	
Required Medical Info	Diagnosis of primary hypogonadism (congenital or acquired) in males. Diagnosis of secondary (hypogonadotropic) hypogonadism (congenital or acquired) in males. Hypogonadism (primary or secondary) in males, serum testosterone level. [Man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.

Other Criteria	Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. Hypogonadism (primary or secondary) in males - continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) AND 2) patient had at least one pre-treatment serum testosterone level that was low. [Note: male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]
Indications	All FDA-approved Indications.
Off-Label Uses	
NORTHERA	
Exclusion Criteria	
Required Medical Info	Medication history
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a neurologist
Coverage Duration	12 months
Other Criteria	NOH, approve if the patient meets ALL of the following criteria: a) Patient has been diagnosed with symptomatic NOH due to primary autonomic failure (Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND b) Patient has tried midodrine
Indications	All FDA-approved Indications.
Off-Label Uses	
NUBEQA	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Prostate cancer - non-metastatic, castration resistant-approve if the requested medication will be used concurrently with a gonadotropin-releasing hormone (GnRH) analog or if the patient has had a bilateral orchiectomy.
Indications	All FDA-approved Indications.
Off-Label Uses	
NUCALA	

Exclusion Criteria	Concurrent use with Xolair or another Anti-Interleukin (IL) Monoclonal Antibody.
Required Medical Info	
Age Restrictions	Asthma-6 years of age and older. EGPA-18 years of age and older. HES-12 years and older.
Prescriber Restrictions	Asthma-Prescribed by or in consultation with an allergist, immunologist, or pulmonologist. EGPA-prescribed by or in consultation with an allergist, immunologist, pulmonologist or rheumatologist. HES-prescribed by or in consultation with an allergist, immunologist, hematologist, pulmonologist or rheumatologist.
Coverage Duration	Initial-Asthma/EGPA-6 months, HES-8 months. 12 months continuation.
Other Criteria	Asthma initial - must have blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6 weeks (prior to treatment with any anti-interleukin (IL)-5 therapy) AND Patient has received at least 3 consecutive months of combination therapy with an inhaled corticosteroid AND at least one additional asthma controller/maintenance medication AND patient's asthma continues to be uncontrolled, or was uncontrolled prior to starting any anti-IL therapy as defined by ONE of the following - patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year, patient has a FEV1 less than 80 percent predicted, Patient has an FEV1/FVC less than 0.80, or Patient's asthma worsens upon tapering of oral corticosteroid therapy. NOTE: An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-5 therapy (e.g., Cinqair, Fasenra, Nucala) used concomitantly with an ICS for at least 3 consecutive months. Continuation - The patient has responded to Nucala therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations, decreased asthma symptoms, decreased hospitalizations, emergency department (ED)/urgent care, or physician visits due to asthma, decreased requirement for oral corticosteroid therapy) AND Patient continues to receive therapy with an inhaled corticosteroid. EGPA initial-patient has/had a blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin (IL)-5 therapy (e.g., Nucala, Cinqair, Fasenra). Continuation-The patient has responded to Nucala therapy as determined by the prescribing physician (e.g., reduced rate of relapse, corticosteroid dose reduction, reduced eosinophil levels). HES initial-patient has had hypereosinophilic syndrome for greater than or equal to 6 months AND has FIP1L1-PDGFRalpha-negative disease AND the patient does NOT have an identifiable non-hematologic secondary cause of hypereosinophilic syndrome AND prior to initiating therapy with any anti-interleukin-5 therapy, the patient has/had a blood eosinophil level of greater than or equal to 1,000 cells per microliter. Continuation-approve if the patient has received at least 8 months of therapy with Nucala (patients who have received less than 8 months of therapy or who are restarting therapy should be reviewed under initial therapy) and patient has responded to Nucala therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	

NUEDEXTA	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
NUPLAZID	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
NURTEC	
Exclusion Criteria	Combination Therapy with Aimovig, Ajovy, Emgality, or Vyepti.
Required Medical Info	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Migraine, Acute treatment-approve. Preventive Treatment of Episodic Migraine-Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least two standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and has had inadequate responses to those therapies or the patient has experienced adverse event(s) severe enough to warrant discontinuation.
Indications	All FDA-approved Indications.
Off-Label Uses	

NUVIGIL/PROVIGIL	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Excessive sleepiness associated with Shift Work Sleep Disorder (SWSD)-approve if the patient is working at least 5 overnight shifts per month. Adjunctive/augmentation treatment for depression in adults if the patient is concurrently receiving other medication therapy for depression. Excessive daytime sleepiness associated with obstructive sleep apnea/hypoapnea syndrome-approve. Excessive daytime sleepiness associated with Narcolepsy-approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Excessive daytime sleepiness (EDS) associated with myotonic dystrophy - modafinil only. Adjunctive/augmentation for treatment of depression in adults - modafinil only.
NYVEPRIA	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist. PBPC-prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in transplantation
Coverage Duration	Cancer pts receiving chemo-6 mo. PBPC-1 mo
Other Criteria	Cancer patients receiving chemotherapy, approve if - the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

Off-Label Uses	Patients undergoing PBPC collection and therapy
OCALIVA	
Exclusion Criteria	
Required Medical Info	Prescriber specialty, lab values, prior medications used for diagnosis and length of trials
Age Restrictions	18 years and older (initial)
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician (initial)
Coverage Duration	6 months initial, 1 year cont.
Other Criteria	Initial treatment of PBC-Patient must meet both 1 and 2-1. Patient has a diagnosis of PBC as defined by TWO of the following:a)Alkaline phosphatase (ALP) elevated above the upper limit of normal as defined by normal laboratory reference values b)Positive anti-mitochondrial antibodies (AMAs) or other PBC-specific auto-antibodies, including sp100 or gp210, if AMA is negative c)Histologic evidence of primary biliary cholangitis (PBC) from a liver biopsy 2. Patient meets ONE of the following: a) Patient has been receiving ursodiol therapy for greater than or equal to 1 year and has had an inadequate response. b) Patient is unable to tolerate ursodiol therapy. Cont tx - approve if the patient has responded to Ocaliva therapy as determined by the prescribing physician (e.g., improved biochemical markers of PBC (e.g., alkaline phosphatase [ALP], bilirubin, gamma-glutamyl transpeptidase [GGT], aspartate aminotransferase [AST], alanine aminotransferase [ALT] levels)).
Indications	All FDA-approved Indications.
Off-Label Uses	
ODACTRA	
Exclusion Criteria	The patient is NOT currently receiving SC or SL allergen immunotherapy
Required Medical Info	Diagnosis
Age Restrictions	Greater than or equal to 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	House Dust Mite (HDM)-Induced Allergic Rhinitis (AR)-approve if the diagnosis is confirmed by meeting ONE of the following conditions (i or ii): i. The patient has a positive skin test response to house dust mite allergen extracts OR ii. The patient has a positive in vitro test (i.e., a blood test for allergen-specific IgE antibodies) for house dust mite (HDM).
Indications	All FDA-approved Indications.
Off-Label Uses	
ODOMZO	
Exclusion Criteria	
Required Medical Info	BCC - Must not have had disease progression while on Erivedge (vismodegib).

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Locally advanced BCC approve if the BCC has recurred following surgery/radiation therapy or if the patient is not a candidate for surgery AND the patient is not a candidate for radiation therapy, according to the prescribing physician. Metastatic BCC - approve.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Metastatic BCC
OFEV	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	18 years of age and older
Prescriber Restrictions	IPF-Prescribed by or in consultation with a pulmonologist. Interstitial lung disease associated with systemic sclerosis-prescribed by or in consultation with a pulmonologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	IPF - must have FVC greater than or equal to 40 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP. Interstitial lung disease associated with systemic sclerosis-approve if the FVC is greater than or equal to 40 percent of the predicted value and the diagnosis is confirmed by high-resolution computed tomography. Chronic fibrosing interstitial lung disease-approve if the forced vital capacity is greater than or equal to 45% of the predicted value AND according to the prescriber the patient has fibrosing lung disease impacting more than 10% of lung volume on high-resolution computed tomography AND according to the prescriber the patient has clinical signs of progression.
Indications	All FDA-approved Indications.
Off-Label Uses	
ONUREG	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years

Other Criteria	AML - Approve if the patient meets the following criteria (both A and B): A)Following intensive induction chemotherapy, the patient achieves one of the following according to the prescriber (i or ii): i. First complete remission OR ii. First complete remission with incomplete blood count recovery AND B) Patient is not able to complete intensive curative therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	
OPSUMIT	
Exclusion Criteria	
Required Medical Info	PAH WHO group, right heart catheterization results, WHO functional status, previous drugs tried
Age Restrictions	
Prescriber Restrictions	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 3 years
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1 patients are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment.
Indications	All FDA-approved Indications.
Off-Label Uses	
ORENCIA	
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
Required Medical Info	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	
Prescriber Restrictions	Initial therapy only-RA and JIA/JRA prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or dermatologist.
Coverage Duration	SC-3 mos initial, 3 years cont
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). Juvenile idiopathic arthritis (JIA) [or Juvenile Rheumatoid Arthritis (JRA)]-approve if the patient has tried one other agent for this condition or the patient will be starting on Orencia concurrently with methotrexate, sulfasalazine or leflunomide or the patient has an absolute contraindication to methotrexate, sulfasalazine or leflunomide or the patient has aggressive disease as determined by the prescribing physician. Cont tx - responded to therapy as per the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	
ORGOVYX	

Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Prostate Cancer-approve.
Indications	All FDA-approved Indications.
Off-Label Uses	
ORKAMBI	
Exclusion Criteria	Combination use with Kalydeco, Trikafta or Symdeko.
Required Medical Info	
Age Restrictions	2 years of age and older
Prescriber Restrictions	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)
Indications	All FDA-approved Indications.
Off-Label Uses	
ORLADEYO	
Exclusion Criteria	Concomitant Use with Other HAE Prophylactic Therapies (e.g., Cinryze, Haegarda, Takhzyro).
Required Medical Info	Diagnosis
Age Restrictions	12 years and older (initial and continuation)
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders. (initial and continuation)
Coverage Duration	Authorization will be for 1 year.
Other Criteria	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] - Prophylaxis, Initial Therapy-the patient has HAE type I or type II as confirmed by the following diagnostic criteria (i and ii): i. the patient has low levels of functional C1-INH protein at baseline, as defined by the laboratory reference values [documentation required] AND ii. the patient has lower than normal serum C4 levels at baseline, as defined by the laboratory reference values [documentation required]. Continuation-According to the prescriber the patient has had a favorable clinical response since initiating Orladeyo prophylactic therapy compared with baseline [documentation required to confirm diagnosis of HAE type I or II for continuation].
Indications	All FDA-approved Indications.

Off-Label Uses	
OTEZLA	
Exclusion Criteria	
Required Medical Info	Diagnosis, previous drugs tried
Age Restrictions	18 years and older (initial)
Prescriber Restrictions	All dx-initial only-PsA - Prescribed by or in consultation with a dermatologist or rheumatologist. PP - prescribed by or in consultation with a dermatologist. Behcet's-prescribed by or in consultation with a dermatologist or rheumatologist
Coverage Duration	4 months initial, 3 years cont
Other Criteria	PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. PsA initial-approve if the patient has tried at least one conventional synthetic DMARD (eg, MTX, leflunomide, sulfasalazine) for at least 3 months, unless intolerant (note: pts who have already tried a biologic DMARD are not required to step back and try a conventional DMARD first). Behcet's-patient has oral ulcers or other mucocutaneous involvement AND patient has tried at least ONE other systemic therapy. PsA/PP/Behcet's- cont - pt has received 4 months of therapy and had a response, as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	
OXERVATE	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an ophthalmologist or an optometrist.
Coverage Duration	2 months
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
PALYNZIQ	
Exclusion Criteria	
Required Medical Info	Diagnosis, phenylalanine concentrations
Age Restrictions	18 years and older

Prescriber Restrictions	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases
Coverage Duration	1 year (initial and continuation)
Other Criteria	Initial therapy - approve if the patient has uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on at least one existing treatment modality (e.g., prior treatment with Kuvan). Maintenance therapy - approve if the patient's blood phenylalanine concentration is less than or equal to 600 micromol/L OR the patient has achieved at least a 20% reduction in blood phenylalanine concentration from pre-treatment baseline.
Indications	All FDA-approved Indications.
Off-Label Uses	
PEMAZYRE	
Exclusion Criteria	
Required Medical Info	Diagnosis, prior therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years
Other Criteria	Cholangiocarcinoma-approve if the patient has unresectable locally advanced or metastatic disease with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement, as detected by an approved test AND the patient has been previously treated with at least one systemic therapy regimen
Indications	All FDA-approved Indications.
Off-Label Uses	
PENICILLAMINE	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	Wilson's Disease-Prescribed by or in consultation with a gastroenterologist, hepatologist or liver transplant physician
Coverage Duration	3 years
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
PHENYLBUTYRATE	
Exclusion Criteria	Concomitant use of Ravicti and Buphenyl
Required Medical Info	Diagnosis, genetic tests and lab results
Age Restrictions	

Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
Coverage Duration	Pt meets criteria with no genetic test - 3 mo approval. Pt had genetic test - 12 mo approval
Other Criteria	Urea cycle disorders-approve if genetic testing confirmed a mutation resulting in a urea cycle disorder or if the patient has hyperammonemia.
Indications	All FDA-approved Indications.
Off-Label Uses	
PHEOCHROMOCYTOMA	
Exclusion Criteria	
Required Medical Info	Diagnosis, prior medication trials
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the management of pheochromocytoma (initial therapy for phenoxybenzamine, initial and continuation therapy for metyrosine)
Coverage Duration	Authorization will be for 1 year
Other Criteria	If the requested drug is metyrosine for initial therapy, approve if the patient has tried a selective alpha blocker (e.g., doxazosin, terazosin or prazosin) AND the patient has tried phenoxybenzamine (brand or generic). If the requested drug is metyrosine for continuation therapy, approve if the patient is currently receiving metyrosine or has received metyrosine in the past.
Indications	All FDA-approved Indications.
Off-Label Uses	
PHOSPHODIESTERASE-5 INHIBITORS FOR PAH	
Exclusion Criteria	
Required Medical Info	Diagnosis, right heart cath results
Age Restrictions	
Prescriber Restrictions	For PAH, if prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment. Clinical criteria incorporated into the quantity limit edits for sildenafil 20 mg tablets and suspension require confirmation that the indication is PAH (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off-Label Uses	
PIQRAY	

Exclusion Criteria	
Required Medical Info	Diagnosis, prior therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Breast Cancer. Approve if the patient meets the following criteria (A, B, C, D, E and F): A) The patient is a postmenopausal female or a male or premenopausal and is receiving ovarian suppression with a gonadotropin-releasing hormone (GnRH) analog AND B) The patient has advanced or metastatic hormone receptor (HR)-positive disease AND C) The patient has human epidermal growth factor receptor 2 (HER2)-negative disease AND D) The patient has PIK3CA-mutated breast cancer as detected by an approved test AND E) The patient has progressed on or after at least one prior endocrine-based regimen (e.g., anastrozole, letrozole, exemestane, Faslodex, tamoxifen, toremifene) AND F) Piqray will be used in combination with fulvestrant injection.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Treatment of breast cancer in premenopausal women
PLEGRIDY	
Exclusion Criteria	Concurrent use of with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Info	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
POMALYST	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years

Other Criteria	CNS Lymphoma-approve if the patient has relapsed or refractory disease. Kaposi Sarcoma-Approve if the patient meets one of the following (i or ii): i. patient is Human Immunodeficiency Virus (HIV)-negative OR ii. patient meets both of the following (a and b): a) The patient is Human Immunodeficiency Virus (HIV)-positive AND b) The patient continues to receive highly active antiretroviral therapy (HAART).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Systemic Light Chain Amyloidosis, Central Nervous System (CNS) Lymphoma
POSACONAZOLE (ORAL)	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Aspergillus/Candida prophy, mucormycosis-6 mo, all others-3 months
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Aspergillus infections - treatment, mouth and esophageal infections (refractory to other azole antifungals) - treatment, mucormycosis - maintenance, fusariosis, invasive - treatment fungal infections (systemic) in patients with human immunodeficiency virus (HIV) infections (e.g., histoplasmosis, coccidioidomycosis) - treatment.
PRALUENT	
Exclusion Criteria	Concurrent use of Juxtapid or Repatha.
Required Medical Info	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	Authorization will be for 3 years.

Other Criteria	Hyperlipidemia in patients with HeFH-approve if meets all of the following 1. Pt has been diagnosed with HeFH AND 2. tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) AND 3. LDL-C remains greater than or equal to 70 mg/dL unless is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. Hyperlipidemia Pt with Clinical ASCVD -approve if meets all of the following: has one of the following conditions prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND tried ONE high intensity statin (as defined above) AND LDL-C remains greater than or equal to 70 mg/dL unless the pt is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. Primary hyperlipidemia (not associated with ASCVD, HeFH, or HoFH)-approve if the patient has tried one high-intensity statin therapy (defined above) and ezetimibe for 8 weeks or longer and LDL remains 100 mg/dL or higher unless statin intolerant (defined above).
Indications	All FDA-approved Indications.
Off-Label Uses	
PROLIA	
Exclusion Criteria	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, Evenity, calcitonin nasal spray [Fortical], abaloparatide), except calcium and Vitamin D.
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 1 year.

Other Criteria	Treatment of postmenopausal osteoporosis/Treatment of osteoporosis in men (to increase bone mass) [a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression], approve if the patient meets one of the following: 1. has had inadequate response after 12 months of therapy with an oral bisphosphonate, had osteoporotic fracture or fragility fracture while receiving an oral bisphosphonate, or intolerability to an oral bisphosphonate, OR 2. the patient cannot take an oral bisphosphonate because they cannot swallow or have difficulty swallowing, they cannot remain in an upright position, or they have a pre-existing GI medical condition, OR 3. pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR 4. the patient has severe renal impairment (eg, creatinine clearance less than 35 mL/min) or chronic kidney disease, or if the patient has an osteoporotic fracture or fragility fracture . Treatment of bone loss in patient at high risk for fracture receiving ADT for nonmetastatic prostate cancer, approve if the patient has prostate cancer that is not metastatic to the bone and the patient is receiving ADT (eg, leuprolide, triptorelin, goserelin) or the patient has undergone a bilateral orchiectomy. Treatment of bone loss (to increase bone mass) in patients at high risk for fracture receiving adjuvant AI therapy for breast cancer, approve if the patient has breast cancer that is not metastatic to the bone and in receiving concurrent AI therapy (eg, anastrozole, letrozole, exemestane). Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture.
Indications	All FDA-approved Indications.
Off-Label Uses	
PROMACTA	
Exclusion Criteria	
Required Medical Info	Cause of thrombocytopenia. Thrombocytopenia due to HCV-related cirrhosis, platelet counts. Severe aplastic anemia, platelet counts and prior therapy. MDS-platelet counts.
Age Restrictions	
Prescriber Restrictions	Thrombocytopenia due to chronic ITP or Aplastic Anemia, approve if prescribed by, or after consultation with, a hematologist (initial therapy). Thrombocytopenia in pt with chronic Hep C, approve if prescribed by, or after consultation with, a gastroenterologist, hematologist, hepatologist, or a physician who specializes in infectious disease (initial therapy). MDS-presc or after consult with heme/onc (initial therapy).
Coverage Duration	Chronic ITP/MDS initial-3 mo, cont 1yr, AA-initial-4 mo, cont-1 yr, Thrombo/Hep C-1 yr

Other Criteria	Thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenia purpura, initial-approve if the patient has a platelet count less than 30, 000 microliters or less than 50, 000 microliters and the patient is at an increased risk for bleeding AND the patient has tried ONE other therapy or has undergone a splenectomy. Cont-approve if the patient demonstrates a beneficial clinical response and remains at risk for bleeding complications. Treatment of thrombocytopenia in patients with Chronic Hepatitis C initial-approve if the patient will be receiving interferon-based therapy for chronic hepatitis C AND to allow for initiation of antiviral therapy if the patient has low platelet counts at baseline (eg, less than 75,000 microliters). Aplastic anemia initial - approve if the patient has low platelet counts at baseline/pretreatment (e.g., less than 30,000 microliters) AND tried one immunosuppressant therapy (e.g., cyclosporine, mycophenolate moefetil, sirolimus) OR patient will be using Promacta in combination with standard immunosuppressive therapy. Cont-approve if the patient demonstrates a beneficial clinical response. MDS initial-approve if patient has low- to intermediate-risk MDS AND the patient has a platelet count less than 30, 000 microliters or less than 50, 000 microliters and is at an increased risk for bleeding. Cont-approve if the patient demonstrates a beneficial clinical response and remains at risk for bleeding complications.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Thrombocytopenia in Myelodysplastic Syndrome (MDS)
PYRIMETHAMINE	
Exclusion Criteria	
Required Medical Info	Patient's immune status
Age Restrictions	
Prescriber Restrictions	Toxoplasma gondii Encephalitis, Chronic Maintenance and Prophylaxis (Primary)-prescribed by or in consultation with an infectious diseases specialist. Toxoplasmosis Treatment-prescribed by or in consultation with an infectious diseases specialist, a maternal-fetal medicine specialist, or an ophthalmologist.
Coverage Duration	12 months
Other Criteria	Toxoplasma gondii Encephalitis, Chronic Maintenance, approve if the patient is immunosuppressed. Toxoplasma gondii Encephalitis Prophylaxis (Primary), approve if the patient is immunosuppressed.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chronic maintenance and prophylaxis of Toxoplasma Gondii encephalitis
QINLOCK	
Exclusion Criteria	
Required Medical Info	Diagnosis, other therapies tried
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years

Other Criteria	Gastrointestinal stromal tumor (GIST), advanced-approve if, according to labeling, the patient has been previously treated with imatinib and at least two other kinase inhibitors, in addition to imatinib.
Indications	All FDA-approved Indications.
Off-Label Uses	
REBIF	
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple sclerosis
Required Medical Info	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
REPATHA	
Exclusion Criteria	Concurrent use of Juxtapid or Praluent.
Required Medical Info	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	ASCVD/HeFH/Primary Hyperlipidemia - 18 yo and older, HoFH 13 yo and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	Approve for 3 years for ASCVD/HeFH/HoFH/primary hyperlipidemia.

Other Criteria	Hyperlipidemia with HeFH - approve if: 1) diagnosis of HeFH AND 2) tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) and LDL remains 70 mg/dL or higher unless pt is statin intolerant defined by experiencing statin related rhabdomyolysis or skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the symptoms resolved upon discontinuation. Hyperlipidemia with ASCVD -approve if: 1) has one of the following conditions: prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND 2) tried ONE high intensity statin (defined above) and LDL remains 70 mg/dL or higher unless pt is statin intolerant (defined above). HoFH - approve if: 1) has one of the following: a) genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus, OR b) untreated LDL greater than 500 mg/dL (prior to treatment), OR c) treated LDL greater than or equal to 300 mg/dL (after treatment but prior to agents such as Repatha, Kynamro or Juxtapid), OR d) has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND 2) tried ONE high intensity statin (defined above) for 8 weeks or longer and LDL remains 70 mg/dL or higher unless statin intolerant (defined above). Primary hyperlipidemia (not associated with ASCVD, HeFH, or HoFH)-approve if the patient has tried one high-intensity statin therapy (defined above) and ezetimibe for 8 weeks or longer and LDL remains 100 mg/dL or higher unless statin intolerant (defined above).
Indications	All FDA-approved Indications.
Off-Label Uses	
RETEVMO	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	Medullary Thyroid Cancer/Thyroid Cancer-12 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-Approve if the patient has metastatic disease AND the tumor is RET fusion-positive. Medullary Thyroid Cancer-approve if the patient has advanced or metastatic RET-mutant disease and the disease requires treatment with systemic therapy.Thyroid Cancer-approve if the patient has advanced or metastatic RET fusion positive disease, the disease is radioactive iodine-refractory (if radioactive iodine is appropriate) and the disease requires treatment with systemic therapy. Anaplastic thyroid cancer-approve if the patient has RET fusion-positive anaplastic thyroid carcinoma.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Anaplastic thyroid carcinoma
REVLIMID	

Exclusion Criteria	
Required Medical Info	Diagnosis and previous therapies or drug regimens tried.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Follicular lymphoma-approve if the patient is using Revlimid in combination with rituximab or has tried at least on prior therapy. MCL-approve. MZL-approve. Multiple myeloma-approve. MDS-approve if the patient meets one of the following: 1) Pt has symptomatic anemia, OR 2) Pt has transfusion-dependent anemia, OR 3) Pt has anemia that is not controlled with an erythroid stimulating agent (eg, Epogen, Procrit [epoetin alfa injection], Aranesp [darbepoetin alfa injection]). Diffuse, Large B Cell Lymphoma (Non-Hodgkin's Lymphoma)-approve if the pt has tried at least one prior therapy. Myelofibrosis-approve if according to the prescriber the patient has anemia and the pt has serum erythropoietin levels greater than or equal to 500 mU/ml. Peripheral T-Cell Lymphoma or T-Cell Leukemia/Lymphoma-approve if the pt has tried at least one other therapy or regimen. CNS cancers (primary)-approve if according to the prescriber the patient has relapsed or refractory disease. Hodgkin lymphoma, classical-approve if the patient has relapsed or refractory disease. Castleman's disease-approve if the patient has relapsed/refractory or progressive disease. AIDS Related Kaposi's Sarcoma-approve if the patient has tried at least one regimen or therapy and the patient has relapsed or refractory disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Systemic Amyloidosis Light Chain, Diffuse Large B Cell Lymphoma (Non-Hodgkin's Lymphoma), Myelofibrosis. Castleman's Disease, Hodgkin lymphoma (Classical), Peripheral T-Cell Lymphoma, T-Cell Leukemia/Lymphoma, Central nervous system cancer (primary), Acquired immune deficiency syndrome (AIDS)-related Kaposi's sarcoma.
RILUZOLE	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, a neuromuscular disease specialist, or a physician specializing in the treatment of ALS.
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
RINVOQ	

Exclusion Criteria	Concurrent use with a biologic or with a targeted synthetic DMARD. Concurrent use with other potent immunosuppressants.
Required Medical Info	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	18 years and older
Prescriber Restrictions	RA, prescribed by or in consultation with a rheumatologist.
Coverage Duration	Authorization will be for 3 months initial, 3 years cont.
Other Criteria	RA initial-approve if the patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). Continuation Therapy - Patient must have responded, as determined by the prescriber
Indications	All FDA-approved Indications.
Off-Label Uses	
ROZLYTREK	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	Solid Tumors-12 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Solid Tumors-Approve if the patient meets the following criteria (A, B, and C): A) The patient has locally advanced or metastatic solid tumor AND B) The patient's tumor has neurotrophic receptor tyrosine kinase (NTRK) gene fusion AND C) The patient meets one of the following criteria (i or ii): i. The patient has progressed on prior therapies OR ii. There are no acceptable standard therapies and the medication is used as initial therapy. Non-Small Cell Lung Cancer-Approve if the patient has ROS1-positive metastatic disease.
Indications	All FDA-approved Indications.
Off-Label Uses	
RUBRACA	
Exclusion Criteria	
Required Medical Info	Diagnosis for which Rubraca is being used. BRCA-mutation (germline or somatic) status. Other medications tried for the diagnosis provided
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3years

Other Criteria	Ovarian, Fallopian Tube or Primary Peritoneal Cancer-treatment-Approve if the patient meets the following criteria (i and ii): i.The patient has a BRCA-mutation (germline or somatic) as confirmed by an approved test, AND ii.The patient has progressed on two or more prior lines of chemotherapy. Maintenance Therapy of Ovarian, Fallopian tube or Primary peritoneal cancer-Approve if the patient is in complete or partial response after at least two platinum-based chemotherapy regimens. Castration-Resistant Prostate Cancer - Approve if the patient meets the following criteria (A, B, C, and D): A) The patient has metastatic disease that is BRCA-mutation positive (germline and/or somatic) AND B) The patient meets one of the following criteria (i or ii): i. The medication is used concurrently with a gonadotropin-releasing hormone (GnRH) analog OR ii. The patient has had a bilateral orchiectomy AND C) The patient has been previously treated with at least one androgen receptor-directed therapy AND D) The patient meets one of the following criteria (i or ii): i. The patient has been previously treated with at least one taxane-based chemotherapy OR ii. The patient is not a candidate or is intolerant to taxane-based chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	
RYDAPT	
Exclusion Criteria	
Required Medical Info	For AML, FLT3 status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	AML (for PDP enrollees) -approve if the patient is FLT3-mutation positive as detected by an approved test. AML (for MAPD enrollees) - approve if the patient is FLT3-mutation positive as detected by an approved test AND the patient is receiving Rydapt in one of the following settings (i, ii, iii, or iv)-i. Induction therapy in combination with cytarabine and daunorubicin OR ii. After standard-dose cytarabine induction/reinduction, along with cytarabine and daunorubicin OR iii. Post remission or consolidation therapy in combination with cytarabine OR iv. Maintenance therapy. Myeloid or lymphoid Neopasms with eosinophilia-approve if the patient has an FGFR1 rearrangement or has an FLT3 rearrangement.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Myeloid or lymphoid Neopasms with eosinophilia
SAMSCA	
Exclusion Criteria	Concurrent use with Jynarque.
Required Medical Info	Serum sodium less than 125 mEq/L at baseline or less marked hyponatremia, defined as serum sodium less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 30 days
Other Criteria	Hyponatremia - Pt must meet ONE of the following: 1. serum sodium less than 125 mEq/L at baseline, OR 2. marked hyponatremia, defined as less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion), OR 3. patient has already been started on Samsca and has received less than 30 days of therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	
SIGNIFOR	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	18 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician or specializes in the treatment of Cushing's syndrome (initial therapy)
Coverage Duration	Cushing's-Initial-4 mo, Cont therapy-1 yr. Pt awaiting surgery or response after radiotherapy-4 mo
Other Criteria	Cushing's disease, initial therapy - approve if, according to the prescribing physician, the patient is not a candidate for surgery, or surgery has not been curative. Cushing's disease, continuation therapy - approve if the patient has already been started on Signifor/Signifor LAR and, according to the prescribing physician, the patient has had a response and continuation of therapy is needed to maintain response.
Indications	All FDA-approved Indications.
Off-Label Uses	
SIMPONI	
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Info	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	UC-18 years and older (initial therapy)
Prescriber Restrictions	All dx-initial only-RA/Ankylosing spondylitis, prescribed by or in consultation with a rheumatologist. Psoriatic arthritis, prescribed by or in consultation with a rheumatologist or dermatologist. UC-prescribed by or in consultation with a gastroenterologist
Coverage Duration	3 mos initial, 3 years cont

Other Criteria	AS approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx PsA-approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx, Stelara, Otezla, Orencia, Xeljanz/XR. RA, approve if the patient has tried two of the following: Enbrel, Humira, Orencia, Rinvoq or Xeljanz/XR. Ulcerative colitis - approve if the patient has had a trial with Humira. Cont tx - must have a response to therapy as according to prescriber
Indications	All FDA-approved Indications.
Off-Label Uses	
SIRTURO	
Exclusion Criteria	Patients weighing less than 15 kg
Required Medical Info	Diagnosis, concomitant therapy
Age Restrictions	Patients 5 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with an infectious diseases specialist
Coverage Duration	9 months
Other Criteria	Tuberculosis, Pulmonary Multidrug-resistant or extensively drug resistant-prescribed as part of a combination regimen with other anti-tuberculosis agents
Indications	All FDA-approved Indications.
Off-Label Uses	
SKYRIZI	
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Info	Diagnosis, Previous medication use
Age Restrictions	18 years of age and older (initial therapy)
Prescriber Restrictions	PP-Prescribed by or in consultation with a dermatologist (initial therapy)
Coverage Duration	3 mos initial, 3 years cont
Other Criteria	Initial Therapy-The patient meets ONE of the following conditions (a or b): a) The patient has tried at least one traditional systemic agent for psoriasis (e.g., methotrexate [MTX], cyclosporine, acitretin tablets, or psoralen plus ultraviolet A light [PUVA]) for at least 3 months, unless intolerant. NOTE: An exception to the requirement for a trial of one traditional systemic agent for psoriasis can be made if the patient has already had a 3-month trial or previous intolerance to at least one biologic (e.g., an adalimumab product [Humira], a certolizumab pegol product [Cimzia], an etanercept product [Enbrel, Erelzi], an infliximab product [e.g., Remicade, Inflectra, Renflexis], Cosentyx [secukinumab SC injection], Ilumya [tildrakizumab SC injection], Siliq [brodalumab SC injection], Stelara [ustekinumab SC injection], Taltz [ixekizumab SC injection], or Tremfya [guselkumab SC injection]). These patients who have already tried a biologic for psoriasis are not required to 'step back' and try a traditional systemic agent for psoriasis)b) The patient has a contraindication to methotrexate (MTX), as determined by the prescribing physician.Continuation Therapy - Patient must have responded, as determined by the prescriber.

Indications	All FDA-approved Indications.
Off-Label Uses	
SOLARAZE	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 6 months.
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
SOMAVERT	
Exclusion Criteria	
Required Medical Info	Diagnosis, previous therapy, concomitant therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	1 year
Other Criteria	Acromegaly-approve if patient meets ONE of the following (i, ii, or iii): i. patient has had an inadequate response to surgery and/or radiotherapy OR ii. The patient is NOT an appropriate candidate for surgery and/or radiotherapy OR iii. The patient is experiencing negative effects due to tumor size (e.g., optic nerve compression) AND patient has (or had) a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal (ULN) based on age and gender for the reporting laboratory.
Indications	All FDA-approved Indications.
Off-Label Uses	
SPRYCEL	
Exclusion Criteria	
Required Medical Info	Diagnosis for which Sprycel is being used. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For CML, new patient must have Ph-positive CML for approval of Sprycel. For ALL, new patient must have Ph-positive ALL for approval of Sprycel. GIST - has D842V mutation AND previously tried Sutent and Gleevec.

Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	GIST, chondrosarcoma, chordoma
STELARA	
Exclusion Criteria	Ustekinumab should not be given in combination with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Info	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	18 years and older CD/UC (initial therapy). PP-6 years and older (initial therapy).
Prescriber Restrictions	Plaque psoriasis.Prescribed by or in consultation with a dermatologist (initial therapy). PsA-prescribed by or in consultation with a rheumatologist or dermatologist (initial therapy). CD/UC-prescribed by or in consultation with a gastroenterologist (initial therapy).
Coverage Duration	PP/PsA Init-3mo,CD/UC load-approve 1 dose IV,CD/UC post IV load-SC 3 mo,cont tx-SC 3 yr
Other Criteria	PP initial - Approve Stelara SC. CD, induction therapy - approve single dose of IV formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD (eg, azathioprine, 6-MP, MTX, certolizumab, vedolizumab, adalimumab, infliximab). UC, initial therapy-approve SC if the patient received a single IV loading dose within 2 months of initiating therapy with Stelara SC. CD, initial therapy (only after receiving single IV loading dose within 2 months of initiating therapy with Stelara SC) - approve 3 months of the SC formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD. PP/PsA/CD/UC cont - approve Stelara SC if according to the prescribing physician, the patient has responded to therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	
STIVARGA	
Exclusion Criteria	
Required Medical Info	Diagnosis for which Stivarga is being used. Prior therapies tried. For metastatic CRC, KRAS/NRAS mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.

Other Criteria	For GIST, patient must have previously been treated with imatinib (Gleevec) and sunitinib (Sutent). For HCC, patient must have previously been treated with at least one tyrosine kinase inhibitor (e.g., Nexavar, Lenvima). Soft tissue sarcoma-approve if the patient has non-adipocytic extremity/superficial trunk, head/neck or retroperitoneal/intra-abdominal sarcoma OR pleomorphic rhabdomyosarcoma. Osteosarcoma-approve if the patient has relapsed/refractory or metastatic disease and the requested medication is being used as subsequent therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Soft tissue Sarcoma, Osteosarcoma
SUCRAID	
Exclusion Criteria	
Required Medical Info	Diagnosis, genetic and lab test results
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, gastroenterologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of congenital diarrheal disorders
Coverage Duration	1 year
Other Criteria	Approve if the patient has a laboratory test demonstrating deficient sucrase or isomaltase activity in duodenal or jejunal biopsy specimens OR patient has a sucrose hydrogen breath test OR has a molecular genetic test demonstrating sucrose-isomaltase mutation in saliva or blood.
Indications	All FDA-approved Indications.
Off-Label Uses	
SUTENT	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.

Other Criteria	Gastrointestinal stromal tumors (GIST), approve if the patient tried imatinib (Gleevec). Chordoma, approve if the patient has recurrent disease. Differentiated thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Medullary thyroid carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). Meningioma, approve if the patient has recurrent or progressive disease. Thymic carcinoma - has tried chemotherapy or radiation therapy. Renal Cell Carcinoma (RCC), clear cell or non-clear cell histology-approve if the patient is at high risk of recurrent clear cell RCC following nephrectomy and Sutent is used for adjuvant therapy or if the patient has relapsed or Stage IV disease. Neuroendocrine tumors of the pancreas-approve for advanced or metastatic disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chordoma, angiosarcoma, solitary fibrous tumor/hemangiopericytoma, alveolar soft part sarcoma (ASPS), differentiated (ie, papillary, follicular, and Hurthle) thyroid carcinoma, medullary thyroid carcinoma, meningioma, thymic carcinoma.
SYMDEKO	
Exclusion Criteria	Patients with unknown CFTR gene mutations, Combination therapy with Orkambi, Kalydeco or Trikafta
Required Medical Info	Diagnosis, specific CFTR gene mutations
Age Restrictions	Six years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - must be homozygous for the F508del mutation or have at least one mutation in the CFTR gene that is responsive to the requested medication.
Indications	All FDA-approved Indications.
Off-Label Uses	
SYMLIN	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
TABRECTA	
Exclusion Criteria	

Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-Approve if the patient has metastatic disease AND the tumor is positive for a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping, as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	
TAFAMIDIS	
Exclusion Criteria	Concomitant use with Onpattro or Tegsedi.Concurrent use of Vyndaqel and Vyndamax.
Required Medical Info	Diagnosis, genetic tests and lab results
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis
Coverage Duration	1 year
Other Criteria	Cardiomyopathy of Wild-Type or Hereditary Transthyretin Amyloidosis-approve if the diagnosis was confirmed by one of the following (i, ii or iii): i. A technetium pyrophosphate scan (i.e., nuclear scintigraphy), ii. Amyloid deposits are identified on cardiac biopsy OR iii. patient had genetic testing which, according to the prescriber, identified a TTR mutation AND Diagnostic cardiac imaging (e.g., echocardiogram, cardiac magnetic imaging) has demonstrated cardiac involvement (e.g., increased thickness of the ventricular wall or interventricular septum).
Indications	All FDA-approved Indications.
Off-Label Uses	
TAFINLAR	
Exclusion Criteria	
Required Medical Info	Diagnosis for which Tafinlar is being used. BRAF V600 mutations
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.

Other Criteria	Melanoma with BRAF V600 mutation AND patient has unresectable, advanced (including Stage III or Stage IV disease) or metastatic melanoma. Note-This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery. For NSCLC, must have BRAF V600E mutation. Thyroid Cancer, anaplastic-must have BRAF V600-positive disease AND Tafinlar will be taken in combination with Mekinist, unless intolerant AND the patient has locally advanced or metastatic anaplastic disease. Thyroid Cancer, differentiated (i.e., papillary, follicular, or Hurthle cell) AND the patient has disease that is refractory to radioactive iodine therapy AND the patient has BRAF-positive disease. Colon or Rectal cancer-approve if the patient meets the following (A, B, and C): A) The patient has BRAF V600E mutation-positive disease AND B) The patient has previously received a chemotherapy regimen for colon or rectal cancer AND C) The agent is prescribed as part of a combination regimen for colon or rectal cancer.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Differentiated Thyroid Cancer, Colon or rectal cancer
TAGRISSO	
Exclusion Criteria	
Required Medical Info	NSCLC - prior therapies and EGFR T790M mutation or EGFR exon 19 deletion or exon 21 (L858R) substitution
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	NSCLC - Must have metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive NSCLC as detected by an approved test AND has progressed on one of the EGFR tyrosine kinase inhibitors (e.g.,Tarceva, Iressa, Vizimpro or Gilotrif) therapy OR Advanced or metastatic Non-Small Cell Lung Cancer (NSCLC) who have EGFR exon 19 deletion or exon 21 (L858R) substitution as detected by an approved test. NSCLC, EGFR Mutation positive-approve if the medication is used as adjuvant therapy after tumor resection and the tumor is positive for EGFR exon 19 deletions or exon 21 L858R mutations as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	
TALZENNA	
Exclusion Criteria	
Required Medical Info	Diagnosis, BRCA mutation status, HER2 status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years

Other Criteria	Locally-advanced or metastatic breast cancer-approve if the patient has germline BRCA mutation-positive AND human epidermal growth factor receptor 2 (HER2) negative disease
Indications	All FDA-approved Indications.
Off-Label Uses	
TARCEVA	
Exclusion Criteria	
Required Medical Info	Advanced, recurrent, or metastatic non small cell lung cancer (NSCLC), EGFR mutation or gene amplification status, pancreatic cancer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Metastatic NSCLC, approve if the patient meets both of the following: 1. patient is EGFR mutation positive, AND 2. patient has EGFR exon 19 deletions OR exon 21 (L858R) substitution mutations as detected by an FDA-approved test. Advanced RCC, approve if the patient has non-clear cell histology. Bone cancer-chordoma-approve if the patient has tried imatinib, dasatinib or sunitinib.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Renal Cell Carcinoma and Bone Cancer-Chordoma.
TARGRETIN ORAL	
Exclusion Criteria	
Required Medical Info	Diagnosis, previous therapies tried
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
Coverage Duration	3 years
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
TARGRETIN TOPICAL	
Exclusion Criteria	
Required Medical Info	Diagnosis, previous therapies tried
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
Coverage Duration	3 years
Other Criteria	

Indications	All FDA-approved Indications.
Off-Label Uses	
TASIGNA	
Exclusion Criteria	
Required Medical Info	Diagnosis for which Tasigna is being used. For indication of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For indication of gastrointestinal stromal tumor (GIST) and ALL, prior therapies tried.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, new patient must have Ph-positive CML for approval of Tasigna. For GIST, patient must have tried TWO of the following - sunitinib (Sutent), imatinib (Gleevec), or regorafenib (Stivarga). For ALL, Approve if the patient has tried one other tyrosine kinase inhibitor that is used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Philadelphia positive Acute Lymphoblastic Leukemia (ALL) and Gastrointestinal Stromal Tumor (GIST).
TAZAROTENE	
Exclusion Criteria	Cosmetic uses
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Acne vulgaris after a trial with at least 1 other topical retinoid product (eg, tretinoin cream/gel/solution/microgel, adapalene).
Indications	All Medically-accepted Indications.
Off-Label Uses	
TAZVERIK	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	Epithelioid Sarcoma-16 years and older, Follicular Lymphoma-18 years and older
Prescriber Restrictions	
Coverage Duration	3 years

Other Criteria	Epitheliod Sarcoma-approve if the patient has metastatic or locally advanced disease and the patient is not eligible for complete resection. Follicular Lymphoma-approve if the patient has relapsed or refractory disease and according to the prescriber, there are no appropriate alternative therapies or the patient's tumor is positive for an EZH2 mutation and the patient has tried at least two prior systemic therapies.
Indications	All FDA-approved Indications.
Off-Label Uses	
TECFIDERA	
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Info	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
TEPMETKO	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	NSCLC-approve if the patient has metastatic disease and the tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping alterations.
Indications	All FDA-approved Indications.
Off-Label Uses	
TERIPARATIDE	
Exclusion Criteria	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Fortical], abaloparatide), except calcium and Vitamin D.
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 years

Other Criteria	Treatment of PMO, approve if pt has tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had an osteoporotic fracture or fragility fracture. Increase bone mass in men (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) with primary or hypogondal osteoporosis/Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture. Patients who have already taken teriparatide for 2 years - approve if the patient is at high risk for fracture.
Indications	All FDA-approved Indications.
Off-Label Uses	
THALOMID	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.

Other Criteria	Erythem Nodosum Leprosum-approve. Multiple Myeloma-approve. Discoid lupus erythematosus or cutaneous lupus erythematosus, approve if the patient has tried at least two other therapies (eg, corticosteroids [oral, topical, intralesional], hydroxychloroquine, tacrolimus [Protopic], methotrexate, dapsone, acitretin [Soriatane]). Myelofibrosis, approve if according to the prescriber the patient has anemia and has serum erythropoietin levels greater than or equal to 500 mU/mL or if the patient has serum erythropoietin level less than 500 mU/mL and experienced no response or loss of response to erythropoietic stimulating agents. Prurigo nodularis, approve. Recurrent aphthous ulcers or aphthous stomatitis, approve if the patient has tried at least two other therapies (eg, topical or intralesional corticosteroids, systemic corticosteroids, topical anesthetics/analgesics [eg, benzocaine lozenges], antimicrobial mouthwashes [eg, tetracycline], acyclovir, colchicine). AIDS Related Kaposi's Sarcoma-approve if the patient has tried at least one regimen or therapy and has relapsed or refractory disease. Castleman's disease-approve if the patient has multicentric Castleman's disease, is negative for the human immunodeficiency virus (HIV) and human herpesvirus-8 (HHV-8) and has hyaline vascular histology.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Discoid lupus erythematosus or cutaneous lupus erythematosus, Myelofibrosis, Prurigo nodularis, Recurrent aphthous ulcers or aphthous stomatitis, AIDS related Kaposi's Sarcoma, Castleman's Disease.
TIBSOVO	
Exclusion Criteria	
Required Medical Info	Diagnosis, IDH1 Status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	AML- approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive, as detected by an approved test. Cholangiocarcinoma-approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive and has been previously treated with at least one chemotherapy regimen (chemotherapy requirement only applies to beneficiaries enrolled in an MA-PD plan). Chondrosarcoma-approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Cholangiocarcinoma, Chondrosarcoma
TOLCAPONE	
Exclusion Criteria	
Required Medical Info	Diagnosis, current medications and medication history
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist

Coverage Duration	1 year
Other Criteria	Parkinson's disease-approve if the patient is currently receiving carbidopa/levodopa therapy and the patient has tried entacapone and according to the prescriber, experienced unacceptable tolerability or could not achieve adequate benefit
Indications	All FDA-approved Indications.
Off-Label Uses	
TOPICAL AGENTS FOR ATOPIC DERMATITIS	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Authorize use in patients who have tried a prescription strength topical corticosteroid (brand or generic) for the current condition. Dermatologic condition on or around the eyes, eyelids, axilla, or genitalia, authorize use without a trial of a prescription strength topical corticosteroid.
Indications	All Medically-accepted Indications.
Off-Label Uses	
TOPICAL RETINOID PRODUCTS	
Exclusion Criteria	Coverage is not provided for cosmetic use.
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off-Label Uses	
TOPIRAMATE/ZONISAMIDE	
Exclusion Criteria	Coverage is not provided for weight loss or smoking cessation.
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 1 year.
Other Criteria	

Indications	All Medically-accepted Indications.
Off-Label Uses	
TRANSDERMAL FENTANYL	
Exclusion Criteria	Acute (i.e., non-chronic) pain.
Required Medical Info	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For pain severe enough to require daily, around-the-clock, long-term opioid treatment, approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Patients with cancer, sickle cell disease, in hospice or who reside in a long term care facility are not required to meet above criteria. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids (including transdermal fentanyl products) require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off-Label Uses	
TRANSMUCOSAL FENTANYL DRUGS	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.

Other Criteria	For breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate). Clinical criteria incorporated into the quantity limit edits for all transmucosal fentanyl drugs require confirmation that the indication is breakthrough cancer pain (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off-Label Uses	
TRIENTINE	
Exclusion Criteria	
Required Medical Info	Diagnosis, medication history, pregnancy status, disease manifestations
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For Wilson's Disease, approve if the patient meets ONE of the following: 1) Patient has tried a penicillamine product and per the prescribing physician the patient is intolerant to penicillamine therapy, OR 2) Per the prescribing physician, the patient has clinical features indicating the potential for intolerance to penicillamine therapy (ie, history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency), OR 3) Per the prescribing physician, the patient has a contraindication to penicillamine therapy, OR 4) The patient has neurologic manifestations of Wilson's disease, OR 5) The patient is pregnant.
Indications	All FDA-approved Indications.
Off-Label Uses	
TRIKAFTA	
Exclusion Criteria	Patients with unknown CFTR gene mutations. Combination therapy with Orkambi, Kalydeco or Symdeko.
Required Medical Info	Diagnosis, specific CFTR gene mutations, concurrent medications
Age Restrictions	Six years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - must have at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive to the requested medication.
Indications	All FDA-approved Indications.
Off-Label Uses	

TUKYSA	
Exclusion Criteria	
Required Medical Info	Diagnosis, prior therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Breast Cancer-approve if the patient has advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-positive disease, has received at least one prior anti-HER2-based regimen in the metastatic setting and Tukysa is used in combination with trastuzumab and capecitabine.
Indications	All FDA-approved Indications.
Off-Label Uses	
TURALIO	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Tenosynovial Giant Cell Tumor (Pigmented Villonodular Synovitis)- approve if, according to the prescriber, the tumor is not amenable to improvement with surgery.
Indications	All FDA-approved Indications.
Off-Label Uses	
TYKERB	
Exclusion Criteria	
Required Medical Info	Diagnosis for which lapatinib is being used. Metastatic breast cancer, HER2 status or hormone receptor (HR) status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.

Other Criteria	HER2-positive advanced or metastatic breast cancer, approve if the patient has received prior therapy with trastuzumab and lapatinib will be used in combination with capecitabine OR lapatinib will be used in combination with trastuzumab. HER2-positive HR positive metastatic breast cancer, approve if the patient is a man receiving a GnRH agonist, a premenopausal or perimenopausal woman receiving ovarian suppression/ablation with a GnRH agonist, surgical bilateral oophorectomy or ovarian radiation or a postmenopausal woman and lapatinib will be used in combination with an aromatase inhibitor, that is letrozole (Femara), anastrozole, or exemestane. In this criteria, man/woman is defined as an individual with the biological traits of a man/woman, regardless of the individual's gender identity or expression. Colon or rectal cancer-approve if the patient has unresectable advanced or metastatic disease that is human epidermal receptor 2 (HER2) amplified and with wild-type RAS and the medication is used as subsequent therapy in combination with trastuzumab (the requirement of use in combination with trastuzumab only applies to beneficiaries enrolled in an MA-PD plan) and the patient has not been previously treated with a HER2-inhibitor. Bone Cancer-chordoma-approve if the patient has epidermal growth-factor receptor (EGFR)-positive recurrent disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Bone cancer-chordoma, colon or rectal cancer
UBRELVY	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Migraine, Acute treatment-approve
Indications	All FDA-approved Indications.
Off-Label Uses	
UKONIQ	
Exclusion Criteria	
Required Medical Info	Diagnosis, prior therapies
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Follicular Lymphoma-approve if the patient has received at least three prior lines of systemic therapy. Marginal Zone Lymphoma-approve if the patient has received at least one prior anti-CD20-based regimen.
Indications	All FDA-approved Indications.

Off-Label Uses	
UPTRAVI	
Exclusion Criteria	
Required Medical Info	Confirmation of right heart catheterization, medication history.
Age Restrictions	
Prescriber Restrictions	PAH must be prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	1 year
Other Criteria	Must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Patient new to therapy must meet a) OR b): a) tried one or is currently taking one oral therapy for PAH for 30 days, unless patient has experienced treatment failure, intolerance, or oral therapy is contraindicated: PDE5 inhibitor (eg, sildenafil, Revatio), endothelin receptor antagonist (ERA) [eg, Tracleer, Letairis or Opsumit], or Adempas, OR b) receiving or has received in the past one prostacyclin therapy for PAH (eg, Orenitram, Ventavis, or epoprostenol injection).
Indications	All FDA-approved Indications.
Off-Label Uses	
VALCHLOR	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Cutaneous Lymphomas (Note-includes mycosis fungoides/Sezary syndrome, primary cutaneous B-cell lymphoma, primary cutaneous CD30+ T-cell lymphoproliferative disorders)-approve. Adult T-Cell Leukemia/Lymphoma-approve if the patient has chronic/smoldering subtype of adult T-cell leukemia/lymphoma.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Adults with T-cell leukemia/lymphoma
VALTOCO	
Exclusion Criteria	
Required Medical Info	Diagnosis, other medications used at the same time
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year

Other Criteria	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
Indications	All FDA-approved Indications.
Off-Label Uses	
VANCOMYCIN	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
VENCLEXTA	
Exclusion Criteria	
Required Medical Info	Diagnosis, prior therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	CLL with or without 17p deletion - approve. SLL-approve. Mantle Cell Lymphoma-approve if the patient has tried one prior therapy. AML-approve if the patient is using Venclexta in combination with either azacitidine, decitabine, or cytarabine.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Mantle Cell Lymphoma
VERZENIO	
Exclusion Criteria	
Required Medical Info	HR status, HER2 status, previous medications/therapies tried, concomitant therapy, menopausal status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years

Other Criteria	Breast cancer - approve advanced or metastatic hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)]disease, and HER2-negative breast cancer when the pt meets ONE of the following 1. Pt is postmenopausal and Verzenio will be used in combination with anastrozole, exemestane, or letrozole 2. pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with GnRH agonist, or has had surgical bilateral oophorectomy, or ovarian irradiation AND Verzenio will be used in combination with anastrozole, exemestane, or letrozole 3. Patient is postmenopausal and meets the following conditions: Verzenio will be used in combination with fulvestrant. 4. patient is premenopausal or perimenopausal and meets the following conditions: The patient is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist, or has had surgical bilateral oophorectomy or ovarian irradiation AND Verzenio will be used in combination with fulvestrant 5. patient is postmenopausal, premenopausal/perimenopausal (patient is receiving ovarian suppression/ablation with GnRH agonist or has had surgical bilateral oophorectomy or ovarian irradiation) or a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) and meets the following conditions: Verzenio will be used as monotherapy AND patient's breast cancer has progressed on at least one prior endocrine therapy (e.g., anastrozole, exemestane, letrozole, tamoxifen, Fareston, exemestane plus everolimus, fulvestrant, everolimus plus fulvestrant or tamoxifen, megestrol acetate, fluoxymesterone, ethinyl estradiol) AND patient has tried chemotherapy for metastatic breast cancer. 6. pt is a man who is receiving GnRH analog AND Verzenio with be used in combination with anastrozole, exemestane or letrozole 7. Patient is a man and Verzenio will be used in combination with fulvestrant
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Men with breast cancer
VITRAKVI	
Exclusion Criteria	
Required Medical Info	Diagnosis, NTRK gene fusion status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Solid tumors - approve if the tumor has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation AND the tumor is metastatic or surgical resection of tumor will likely result in severe morbidity AND there are no satisfactory alternative treatments or the patient has disease progression following treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	

VIZIMPRO	
Exclusion Criteria	
Required Medical Info	Diagnosis, EGFR status, exon deletions or substitutions
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Metastatic-NSCLC-Epidermal Growth Factor Receptor (EGFR) mutation positive AND has epidermal growth factor receptor (EGFR) exon 19 deletion as detected by an approved test OR exon 21 (L858R) substitution mutations as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	
VORICONAZOLE (ORAL)	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Aspergillus-Prophy, systemic w/risk neutropenia-Prophy, systemic w/HIV-Prophy/Tx-6 mo, others-3 mo
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Aspergillus Infections - prophylaxis, oropharyngeal candidiasis (fluconazole-refractory) - treatment, candidia endophthalmitis - treatment, blastomycosis - treatment, fungal infections (systemic) in patients at risk of neutropenia - prophylaxis, fungal infections (systemic) in patients with human immunodeficiency virus (HIV) - prophylaxis or treatment.
VOSEVI	
Exclusion Criteria	
Required Medical Info	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance

VOTRIENT	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Soft tissue sarcoma other than GIST [angiosarcoma, Pleomorphic rhabdomyosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma that is unresectable or progressive, soft tissue sarcoma of the extremity/superficial trunk or head/neck, including synvovial sarcoma, or solitary fibrous tumor/hemangiopericytoma or alveolar soft part sarcoma], approve. Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Uterine sarcoma, approve if the patient has recurrent, advanced or metastatic disease. Advanced Renal Cell Carcinoma, Clear Cell or non-Clear Cell histology-approved if the patient has relapsed or stage IV disease. Ovarian Cancer (ie, Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer) - approve if the patient has persistent or recurrent disease. GIST - approve if the patient has tried TWO of the following: Gleevec, Sutent, or Stivarga. Medullary Thyroid Carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Differentiated (ie, papillary, follicular, Hurthle cell) thyroid carcinoma. Uterine sarcoma, Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer, Gastrointestinal Stromal Tumor (GIST), Medullary thyroid carcinoma.
VUMERITY	
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Info	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of MS.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	
Indications	All FDA-approved Indications.
Off-Label Uses	
XALKORI	
Exclusion Criteria	
Required Medical Info	ALK status, high level MET amplification status, MET Exon 14 skipping mutation, and ROS1. For soft tissue sarcoma IMT, ALK translocation.

Age Restrictions	Anaplastic large cell lymphoma-patients greater than or equal to 1 year of age and less than 21 years of age
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	NSCLC, must be ALK-positive as detected by an approved test, have high level MET amplification, have MET Exon 14 skipping mutation, or have ROS1 rearrangement. Anaplastic Large Cell Lymphoma-approve if the patient has anaplastic lymphoma kinase (ALK)-positive disease AND has received at least one prior systemic treatment .
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Soft tissue sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK translocation, NSCLC with high level MET amplification or MET Exon 14 skipping mutation.
XELJANZ	
Exclusion Criteria	Concurrent use with a biologic or with a Targeted Synthetic DMARD for an inflammatory condition (eg, tocilizumab, anakinra, abatacept, rituximab, certolizumab pegol, etanercept, adalimumab, infliximab, golimumab). Concurrent use with potent immunosuppressants that are not methotrexate (MTX) [eg, azathioprine, tacrolimus, cyclosporine, mycophenolate mofetil].
Required Medical Info	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	
Prescriber Restrictions	RA, JIA/JRA prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or a dermatologist. UC-prescribed by or in consultation with a gastroenterologist.
Coverage Duration	PsA/RA/JIA/JRA-3 months initial, UC-16 weeks initial, 3 years cont.
Other Criteria	RA/PsA initial, approve Xeljanz/XR if the patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). UC-Approve Xeljanz/XR if the patient has tried at least ONE tumor necrosis factor inhibitor for ulcerative colitis. Juvenile Idiopathic Arthritis (JIA) [or Juvenile Rheumatoid Arthritis] (regardless of type of onset) [Note: This includes patients with juvenile spondyloarthropathy/active sacroiliac arthritis]-initial-approve Xeljanz tablets (not the XR formulation) or oral solution if the patient meets ONE of the following: patient has tried one other medication (Note: Examples of other medications for JIA include methotrexate, sulfasalazine, or leflunomide, a nonsteroidal anti-inflammatory drug (NSAID). A previous trial of a biologic also counts as a trial of one medication.) for this condition OR Patient has aggressive disease. Continuation Therapy - Patient must have responded, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	
XENAZINE	
Exclusion Criteria	

Required Medical Info	
Age Restrictions	
Prescriber Restrictions	For treatment of chorea associated with Huntington's disease, Tourette syndrome or related tic disorders, hyperkinetic dystonia, or hemiballism, must be prescribed by or after consultation with a neurologist. For TD, must be prescribed by or after consultation with a neurologist or psychiatrist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Tardive dyskinesia (TD). Tourette syndrome and related tic disorders. Hyperkinetic dystonia. Hemiballism.
XERMELO	
Exclusion Criteria	
Required Medical Info	Diagnosis, previous therapy, concomitant therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Initial therapy - approve if the patient meets ALL of the following criteria: 1) patient has been on long-acting somatostatin analog (SSA) therapy (eg, Somatuline Depot [lanreotide for injection]) AND 2) while on long-acting SSA therapy (prior to starting Xermelo), the patient continues to have at least four bowel movements per day, AND 3) Xermelo will be used concomitantly with a long-acting SSA therapy. Continuation therapy - approve if the patient is continuing to take Xermelo concomitantly with a long-acting SSA therapy for carcinoid syndrome diarrhea.
Indications	All FDA-approved Indications.
Off-Label Uses	
XOLAIR	
Exclusion Criteria	Concurrent use with an Interleukin (IL) Antagonist Monoclonal Antibody
Required Medical Info	Moderate to severe persistent asthma, baseline IgE level of at least 30 IU/mL. For asthma, patient has a baseline positive skin test or in vitro testing (ie, a blood test for allergen-specific IgE antibodies such as an enzyme-linked immunoabsorbant assay (eg, immunoCAP, ELISA) or the RAST) for 1 or more perennial aeroallergens (eg, house dust mite, animal dander [dog, cat], cockroach, feathers, mold spores) and/or for 1 or more seasonal aeroallergens (grass, pollen, weeds). CIU - must have urticaria for more than 6 weeks (prior to treatment with Xolair), with symptoms present more than 3 days/wk despite daily non-sedating H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine).
Age Restrictions	Moderate to severe persistent asthma-6 years and older. CIU-12 years and older. Polyps-18 years and older.

Prescriber Restrictions	Moderate to severe persistent asthma if prescribed by, or in consultation with an allergist, immunologist, or pulmonologist. CIU if prescribed by or in consultation with an allergist, immunologist, or dermatologist. Polyps-prescribed by or in consult with an allergist, immunologist, or otolaryngologist.
Coverage Duration	asthma/CIU-Initial tx 4 months, Polyps-initial-6 months, continued tx 12 months
Other Criteria	Moderate to severe persistent asthma approve if pt meets criteria 1 and 2: 1) pt has received at least 3 months of combination therapy with an inhaled corticosteroid and at least one the following: long-acting beta-agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist, or theophylline, and 2) patient's asthma is uncontrolled or was uncontrolled prior to receiving any Xolair or anti-IL-4/13 therapy (Dupixent) therapy as defined by ONE of the following (a, b, c, d, or e): a) The patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year OR b) The patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year OR c) Patient has a forced expiratory volume in 1 second (FEV1) less than 80% predicted OR d) Patient has an FEV1/forced vital capacity (FVC) less than 0.80 OR e) The patient's asthma worsens upon tapering of oral corticosteroid therapy NOTE: An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-4/13 therapy (Dupixent) used concomitantly with an ICS for at least 3 consecutive months. For continued Tx for asthma - patient has responded to therapy as determined by the prescribing physician and continues to receive therapy with one inhaled corticosteroid or inhaled corticosteroid containing combination product. For CIU cont tx - must have responded to therapy as determined by the prescribing physician. Nasal Polyps Initial-Approve if the patient has a baseline IgE level greater than or equal to 30 IU/ml, patient is experiencing significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea, or reduction/loss of smell and patient is currently receiving therapy with an intranasal corticosteroid. Nasal polyps continuation-approve if the patient continues to receive therapy with an intranasal corticosteroid and has responded to therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	
XOSPATA	
Exclusion Criteria	
Required Medical Info	Diagnosis, FLT3-mutation status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years

Other Criteria	AML - approve if the patient has relapsed or refractory disease AND the disease is FLT3-mutation positive as detected by an approved test. Lymphoid, Myeloid, or Mixed Lineage Neoplasms-approve if the patient has eosinophilia and the disease is FLT3-mutation positive as detected by an approved test.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Lymphoid, Myeloid, or Mixed Lineage Neoplasms
XPOVIO	
Exclusion Criteria	
Required Medical Info	Diagnosis, prior therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Multiple Myeloma-Approve if the patient meets the following (A and B): A) The medication will be taken in combination with dexamethasone AND B) Patient meets one of the following (i, ii, or iii): i. Patient has tried at least four prior regimens for multiple myeloma OR ii. Patient meets both of the following (a and b): a) Patient has tried at least one prior regimen for multiple myeloma AND b) The medication will be taken in combination with bortezomib OR iii. Patient meets both of the following (a and b): a) Patient has tried at least one prior regimen for multiple myeloma AND b) The medication will be taken in combination with Darzalex (daratumumb infusion), Darzlaex Faspro (daratumumab and hyaluronidase-fihj injection), or Pomalyst (pomalidomide capsules). Note: Examples include bortezomib/Revlimid (lenalidomide capsules)/dexamethasone, Kyprolis (carfilzomib infusion)/Revlimid/dexamethasone, Darzalex (daratumumab injection)/bortezomib or Kyprolis/dexamethasone, or other regimens containing a proteasome inhibitor, immunomodulatory drug, and/or anti-CD38 monoclonal antibody. Diffuse large B-cell lymphoma-approve if the patient has been treated with at least two prior systemic therapies.
Indications	All FDA-approved Indications.
Off-Label Uses	
XTANDI	
Exclusion Criteria	
Required Medical Info	Diagnosis for which Xtandi is being used.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Prostate cancer-castration-resistant (CRPC) [Metastatic or Non-metastatic] and Prostate cancer-metastatic, castration sensitive-approve if Xtandi will be used concurrently with a gonadotropin-releasing hormone (GnRH) analog or if the patient has had a bilateral orchiectomy.

Indications	All FDA-approved Indications.
Off-Label Uses	
XURIDEN	
Exclusion Criteria	
Required Medical Info	Diagnosis, lab results
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a metabolic specialist, geneticist or physician specializing in the condition being treated
Coverage Duration	1 year
Other Criteria	Hereditary orotic aciduria (Orotic aciduria Type 1)-Approve if the patient has molecular genetic testing confirming mutation in the UMPS gene or clinical diagnosis supported by first degree family relative (i.e., parent or sibling) with hereditary orotic aciduria and urinary orotic acid level above the normal reference range for the reporting laboratory.
Indications	All FDA-approved Indications.
Off-Label Uses	
XYREM	
Exclusion Criteria	
Required Medical Info	Medication history
Age Restrictions	
Prescriber Restrictions	Prescribed by a sleep specialist physician or a Neurologist
Coverage Duration	12 months.
Other Criteria	For Excessive daytime sleepiness (EDS) in patients with narcolepsy - approve if the patient has tried one CNS stimulant (e.g., methylphenidate, dexmethylphenidate, dextroamphetamine), modafinil, or armodafinil and narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT). Cataplexy treatment in patients with narcolepsy-approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT).
Indications	All FDA-approved Indications.
Off-Label Uses	
YONSA	
Exclusion Criteria	
Required Medical Info	Diagnosis, concomitant medications
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years

Other Criteria	Metastatic castration-resistant prostate cancer (mCRPC) - approve if the patient will be using Yonsa in combination with methylprednisolone.
Indications	All FDA-approved Indications.
Off-Label Uses	
ZARXIO	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. Radiation-expertise in acute radiation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
Coverage Duration	chem/SCN/AML-6 mo.HIV/AIDS-4 mo.MDS/BMT-3 mo.PBPC,Drug induce A/N,AA,ALL-3 mo.Radi-1 mo.other=12mo
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, or HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, filgramstim products, pegfilgrastim products) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL). Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome).
ZEJULA	

Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Ovarian, fallopian tube, or primary peritoneal cancer, maintenance therapy - approve if the patient is in complete or partial response after platinum-based chemotherapy regimen. Ovarian, fallopian tube, or primary peritoneal cancer, treatment-approve per label if the patient has tried at least three prior chemotherapy regimens and has homologous recombination deficiency (HRD)-positive disease as confirmed by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	
ZELBORAF	
Exclusion Criteria	
Required Medical Info	BRAFV600 mutation status required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Melanoma, patient new to therapy must have BRAFV600 mutation for approval AND have unresctable, advanced or metastatic melanoma. HCL - must have relapsed or refractory disease AND tried at least one other therapy for hairy cell leukemia.Thyroid Cancer-patient has disease that is refractory to radioactive iodine therapy. Colon or Rectal cancer-approve if the patient meets the following (A, B, and C): A) The patient has BRAF V600E mutation-positive disease AND B) The patient has previously received a chemotherapy regimen for colon or rectal cancer AND C) The agent is prescribed as part of a combination regimen for colon or rectal cancer. Erdheim-Chester disease, in patients with the BRAF V600 mutation-approve.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Hairy Cell Leukemia, Non-Small Cell Lung Cancer (NSCLC) with BRAF V600E Mutation, Differentiated thyroid carcinoma (i.e., papillary, follicular, or Hurthle cell) with BRAF-positive disease, patients with colon or rectal cancer
ZEPOSIA	
Exclusion Criteria	MS-Concurrent use with other disease-modifying agents used for multiple sclerosis. UC- Concurrent Use with a Biologic or with a Targeted Synthetic Disease-modifying Antirheumatic Drug (DMARD) for Ulcerative Colitis.
Required Medical Info	Diagnosis
Age Restrictions	UC-18 years and older

Prescriber Restrictions	MS-Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis. UC-Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	1 year
Other Criteria	Ulcerative Colitis- Patients new to therapy are required to try Humira (a trial of Simponi SC or infliximab would also count) AND Stelara (a trial of Entyvio or Stelara IV would also count).
Indications	All FDA-approved Indications.
Off-Label Uses	
ZIEXTENZO	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist. PBPC-prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in transplantation.
Coverage Duration	Cancer pts receiving chemo-6 mo. PBPC-1 mo
Other Criteria	Cancer patients receiving chemotherapy, approve if-the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients undergoing PBPC collection and therapy
ZOLINZA	
Exclusion Criteria	
Required Medical Info	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years

Other Criteria	Cutaneous T-Cell Lymphoma including Mycosis Fungoides/Sezary Syndrome-approve.
Indications	All FDA-approved Indications.
Off-Label Uses	
ZYDELIG	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	CLL-approve if the patient has tried two prior therapies. Marginal Zone Lymphoma/Follicular Lymphoma/SLL - approve if the patient has tried two prior therapies.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Marginal Zone Lymphoma
ZYKADIA	
Exclusion Criteria	
Required Medical Info	Must have metastatic NSCLC that is anaplastic lymphoma kinase (ALK)-positive as detected by an approved test or ROS1 Reaarangement. IMT - ALK Translocation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Soft Tissue Sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK Translocation. Patients with NSCLC with ROS1 Rearrangement-First-line therapy.
ZYTIGA	
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.

Other Criteria	Prostate Cancer-Metastatic, Castration-Resistant (mCRPC) and Metastatic, Castration-Sensitive (mCSPC), high risk- Approve if abiraterone is being used in combination with prednisone and the medication is concurrently used with a gonadotropin-releasing hormone (GnRH) analog or the patient has had a bilateral orchiectomy. Prostate Cancer - Regional Risk Group - Approve if the patient meets all of the following criteria (A, B, and C): A) abiraterone is used in combination with prednisone AND B) Patient has regional lymph node metastases and no distant metastases AND C) Patient meets one of the following criteria (i or ii): i. abiraterone with prednisone is used in combination with gonadotropin-releasing hormone (GnRH) analog (e.g., Lupron [leuprolide acetate for injection], Lupron Depot [leuprolide acetate for depot suspension], Trelstar [triptorelin pamoate for injectable suspension], Zoladex [goserelin acetate implant], Vantas [histrelin acetate subcutaneous implant], Firmagon) OR ii. Patient has had an orchiectomy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Prostate Cancer-Regional Risk Group

The following drugs 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.	
Drug Name	**Route of Administration / Dosage Form**
ABELCET	INTRAVENOUS SUSPENSION
ACETYLCYSTEINE	SOLUTION
ACTIMMUNE	SUBCUTANEOUS SOLUTION
ACYCLOVIR SODIUM	INTRAVENOUS SOLUTION
ALBUTEROL SULFATE	INHALATION SOLUTION FOR NEBULIZATION 0.63 MG/3 ML, 1.25 MG/3 ML, 2.5 MG /3 ML (0.083 %), 2.5 MG/0.5 ML
AMBISOME	INTRAVENOUS SUSPENSION FOR RECONSTITUTION
AMINOSYN II 15 %	INTRAVENOUS PARENTERAL SOLUTION
AMINOSYN-PF 7 % (SULFITE-FREE)	INTRAVENOUS PARENTERAL SOLUTION
AMPHOTERICIN B	INJECTION RECON SOLN
APREPITANT	ORAL CAPSULE
APREPITANT	ORAL CAPSULE,DOSE PACK
AZATHIOPRINE	ORAL TABLET
BETHKIS	INHALATION SOLUTION FOR NEBULIZATION
BUDESONIDE	INHALATION SUSPENSION FOR NEBULIZATION 0.25 MG/2 ML, 0.5 MG/2 ML, 1 MG/2 ML

CASPOFUNGIN	INTRAVENOUS RECON SOLN
CLINIMIX 5%/D15W SULFITE FREE	INTRAVENOUS PARENTERAL SOLUTION
CLINIMIX 4.25%/D10W SULF FREE	INTRAVENOUS PARENTERAL SOLUTION
CLINIMIX 4.25%/D5W SULFIT FREE	INTRAVENOUS PARENTERAL SOLUTION
CLINIMIX 5%-D20W(SULFITE-FREE)	INTRAVENOUS PARENTERAL SOLUTION
CROMOLYN	INHALATION SOLUTION FOR NEBULIZATION
CYCLOPHOSPHAMIDE	ORAL CAPSULE
CYCLOPHOSPHAMIDE	ORAL TABLET
CYCLOSPORINE MODIFIED	ORAL CAPSULE
CYCLOSPORINE MODIFIED	ORAL SOLUTION
CYCLOSPORINE	ORAL CAPSULE
DRONABINOL	ORAL CAPSULE
EMEND	ORAL SUSPENSION FOR RECONSTITUTION
ENGERIX-B (PF)	INTRAMUSCULAR SYRINGE
ENGERIX-B PEDIATRIC (PF)	INTRAMUSCULAR SYRINGE
ENVARSUS XR	ORAL TABLET EXTENDED RELEASE 24 HR
EVEROLIMUS (IMMUNOSUPPRESSIVE)	ORAL TABLET
FIRMAGON KIT W DILUENT SYRINGE	SUBCUTANEOUS RECON SOLN
GENGRAF	ORAL CAPSULE
GENGRAF	ORAL SOLUTION
GRANISETRON HCL	ORAL TABLET

HEPATAMINE 8%	INTRAVENOUS PARENTERAL SOLUTION
INTRALIPID	INTRAVENOUS EMULSION 20 %
INTRON A	INJECTION RECON SOLN
INTRON A	INJECTION SOLUTION
IPRATROPIUM BROMIDE	INHALATION SOLUTION
IPRATROPIUM-ALBUTEROL	INHALATION SOLUTION FOR NEBULIZATION
LEVALBUTEROL HCL	INHALATION SOLUTION FOR NEBULIZATION
METHOTREXATE SODIUM (PF)	INJECTION SOLUTION
METHOTREXATE SODIUM	INJECTION SOLUTION
METHOTREXATE SODIUM	ORAL TABLET
METHYLPREDNISOLONE	ORAL TABLET
MILLIPRED	ORAL TABLET
MYCOPHENOLATE MOFETIL	ORAL CAPSULE
MYCOPHENOLATE MOFETIL	ORAL SUSPENSION FOR RECONSTITUTION
MYCOPHENOLATE MOFETIL	ORAL TABLET
MYCOPHENOLATE SODIUM	ORAL TABLET,DELAYED RELEASE (DR/EC)
ONDANSETRON HCL	ORAL SOLUTION
ONDANSETRON HCL	ORAL TABLET 4 MG, 8 MG
ONDANSETRON	ORAL TABLET,DISINTEGRATING
PENTAMIDINE	INHALATION RECON SOLN
PERFOROMIST	INHALATION SOLUTION FOR NEBULIZATION
PLENAMINE	INTRAVENOUS PARENTERAL SOLUTION
PREDNISONE INTENSOL	ORAL CONCENTRATE

PREDNISONE	ORAL TABLET
PREMASOL 10 %	INTRAVENOUS PARENTERAL SOLUTION
PROGRAF	ORAL GRANULES IN PACKET
PULMOZYME	INHALATION SOLUTION
RECOMBIVAX HB (PF)	INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML
RECOMBIVAX HB (PF)	INTRAMUSCULAR SYRINGE
SANDIMMUNE	ORAL SOLUTION
SIROLIMUS	ORAL SOLUTION
SIROLIMUS	ORAL TABLET
SYNRIBO	SUBCUTANEOUS RECON SOLN
TACROLIMUS	ORAL CAPSULE
TOBRAMYCIN IN 0.225 % NACL	INHALATION SOLUTION FOR NEBULIZATION
TOBRAMYCIN	INHALATION SOLUTION FOR NEBULIZATION
TRAVASOL 10 %	INTRAVENOUS PARENTERAL SOLUTION
TRELSTAR	INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION
TROPHAMINE 10 %	INTRAVENOUS PARENTERAL SOLUTION
VARUBI	ORAL TABLET
XATMEP	ORAL SOLUTION
XGEVA	SUBCUTANEOUS SOLUTION
ZORTRESS	ORAL TABLET 1 MG