

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

You will need authorization by your Medicare Part D Employer Group plan before filling prescriptions for the drugs shown in the chart below. Highmark Blue Cross Blue Shield 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/pharmacy](http://www.bcbswny.com/pharmacy)

<b>PRIOR AUTHORIZATION MEDICATIONS</b>	
<b>ACTEMRA SQ</b>	
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
<b>Required Medical Info</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	Interstitial lung disease-18 years and older (initial and continuation)
<b>Prescriber Restrictions</b>	RA/GCA/PJIA/SJIA - Prescribed by or in consultation with a rheumatologist (initial therapy only). Lung disease-presc/consult-pulmonologist or rheum (initial and cont)
<b>Coverage Duration</b>	GCA-6mo initial, 1yr cont.PJIA-4mo initial, 1yr cont. other dx-3mo initial, 1yr cont. Lung dx-1 yr
<b>Other Criteria</b>	RA initial - approve if the patient meets one of the following (A or B): patient has tried TWO of the following drugs in the past: Enbrel, Humira, Orencia, Rinvoq or Xeljanz/XR (Note: if the patient does not meet this requirement, previous trial(s) with the following drugs will be counted towards meeting the try TWO requirement: Cimzia, infliximab, golimumab SC/IV), OR B) patient has heart failure or a previously treated lymphoproliferative disorder. PJIA initial, approve if the patient meets one of the following (A or B): patient has tried TWO of the following: Enbrel, Orencia, Xeljanz or Humira. (Note: if the patient does not meet this requirement, previous trial with the drug infliximab will be counted towards meeting the try TWO requirement), OR B) patient has heart failure or a previously treated lymphoproliferative disorder. Cont tx, RA/PJIA - approve if the pt 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. Interstitial lung disease assoc with systemic sclerosis, Cont tx-approve if the patient had adequate efficacy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ACYCLOVIR (TOPICAL)</b>	
<b>Exclusion Criteria</b>	

<b>Required Medical Info</b>	Medication history
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ADBRY</b>	
<b>Exclusion Criteria</b>	Concurrent use with another monoclonal antibody therapy
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years of age and older (initial therapy)
<b>Prescriber Restrictions</b>	Atopic Dermatitis-prescribed by or in consultation with an allergist, immunologist or dermatologist (initial therapy)
<b>Coverage Duration</b>	Initial-Atopic Dermatitis-4 months, Continuation-1 year
<b>Other Criteria</b>	Atopic Dermatitis, initial-patient has atopic dermatitis involvement estimated to be greater than or equal to 10 percent of the body surface area and patients meets a and b: a. Patient has tried at least one medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroid AND b. Inadequate efficacy was demonstrated with the previously tried topical corticosteroid therapy. Continuation- Approve if the patient has been receiving Adbry for at least 4 months and patient has responded to therapy. Note: A patient who has received less than 4 months of therapy or who is restarting therapy with Adbry should be considered under initial therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ADEMPAS</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PAH and CTEPH- must be prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>AIMOVIG</b>	
<b>Exclusion Criteria</b>	Combination therapy with Ajovy, Vyepiti or Emgality

<b>Required Medical Info</b>	Diagnosis, number of migraine headaches per month, prior therapies tried
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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 one standard prophylactic pharmacologic therapy(e.g., anticonvulsant, beta-blocker), and has had inadequate response or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**AJOVY**

<b>Exclusion Criteria</b>	Combination therapy with Aimovig, Vyepti or Emgality
<b>Required Medical Info</b>	Diagnosis, number of migraine headaches per month, prior therapies tried
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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 one standard prophylactic pharmacologic therapy (e.g., anticonvulsant, beta-blocker), and has had inadequate response or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**ALECENSA**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	metastatic NSCLC - is anaplastic lymphoma kinase (ALK)-positive as detected by an approved test.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**ALPHA 1 PROTEINASE INHIBITORS**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease)-approve if the patient has a baseline (pretreatment) AAT serum concentration of less than 80 mg/dL or 11 micromol/L.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**ALUNBRIG**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	ALK status
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Metastatic NSCLC, must be ALK-positive, as detected by an approved test.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**ANABOLIC STEROIDS**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	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)**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis

<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**ANTIFUNGALS (IV)**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**ARCALYST**

<b>Exclusion Criteria</b>	Concurrent biologic therapy
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	Initial tx CAPS/Pericarditis-Greater than or equal to 12 years of age.
<b>Prescriber Restrictions</b>	Initial tx CAPS-prescribed by, or in consultation with, a rheumatologist, geneticist, allergist/immunologist, or dermatologist. DIRA initial-rheum, geneticist, dermatologist, or a physician specializing in the treatment of autoinflammatory disorders. Pericarditis-cardiologist or rheum
<b>Coverage Duration</b>	CAPS-3 mos initial, 1 yr cont. DIRA-6 mos initial, 1 yr cont. Pericard-3 mos initial, 1 yr cont
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**ARIKAYCE**

<b>Exclusion Criteria</b>	
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<b>Required Medical Info</b>	Diagnosis, previous medication history
<b>Age Restrictions</b>	MAC-18 years and older
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	MAC Lung disease-approve if the patient has NOT achieved negative sputum cultures for Mycobacterium avium complex within the past 3 months after completion of 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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Cystic fibrosis pseudomonas aeruginosa infection

### AUBAGIO

<b>Exclusion Criteria</b>	Concurrent use of Aubagio with other disease-modifying agents used for multiple sclerosis (MS)
<b>Required Medical Info</b>	Relapsing form of MS, to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### AVONEX

<b>Exclusion Criteria</b>	Concurrent use of other disease-modifying agent used for multiple sclerosis
<b>Required Medical Info</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### AYVAKIT

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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. Systemic mastocytosis-Approve if the patient has a platelet count greater than or equal to 50,000/mcL and patient has one of the following subtypes of advanced systemic mastocytosis-aggressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm or mast cell leukemia.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Myeloid/Lymphoid neoplasms with Eosinophilia

### BAFIERTAM

<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of MS.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### BALVERSA

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, previous therapies, test results
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.

<b>Off-Label Uses</b>	
<b>BENLYSTA</b>	
<b>Exclusion Criteria</b>	Concurrent Use with Other Biologics
<b>Required Medical Info</b>	Diagnosis, medications that will be used in combination, autoantibody status
<b>Age Restrictions</b>	18 years and older (initial).
<b>Prescriber Restrictions</b>	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)
<b>Coverage Duration</b>	SLE-Initial-4 months, cont-1 year. Lupus Nephritis-6 mo initial, 1 year cont
<b>Other Criteria</b>	Lupus Nephritis Initial-approve if the patient has autoantibody-positive SLE, defined as 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, defined as 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>BESREMI</b>	
<b>Exclusion Criteria</b>	Concomitant use with other interferon products
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>BETASERON/EXTAVIA</b>	
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis



<b>Required Medical Info</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>BEXAROTENE (ORAL)</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, previous therapies tried
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>BOSENTAN/AMBRISENTAN</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Pulmonary arterial hypertension (PAH) WHO Group 1, results of right heart cath
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Chronic thromboembolic pulmonary hypertension (CTEPH) (bosentan)
<b>BOSULIF</b>	
<b>Exclusion Criteria</b>	

<b>Required Medical Info</b>	Diagnosis. For CML/ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For ALL, prior therapies tried
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	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).
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients with Philadelphia chromosome positive Acute Lymphoblastic Leukemia
<b>BRAFTOVI</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, BRAF V600 status
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>BRUKINSA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, prior therapies
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Chronic lymphocytic Leukemia (CLL). Small Lymphocytic Lymphoma (SLL)
<b>C1 ESTERASE INHIBITORS</b>	

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II], Prophylaxis, Initial Therapy: approve if the patient has HAE type I or type II confirmed by low levels of functional C1-INH protein (less than 50% of normal) at baseline and lower than normal serum C4 levels at baseline. Patient is currently taking Cinryze for prophylaxis - approve if the patient meets the following criteria (i and ii): i) patient has a diagnosis of HAE type I or II, and ii) according to the prescriber, the patient has had a favorable clinical response since initiating Cinryze as prophylactic therapy compared with baseline. HAE Due to C1-INH Deficiency [Type I or Type II], Treatment of Acute Attacks, Initial Therapy: approve if the patient has HAE type I or type II confirmed by low levels of functional C1-INH protein (less than 50% of normal) at baseline and lower than normal serum C4 levels at baseline. Patient who has treated previous acute HAE attacks with Cinryze: approve if the patient has a diagnosis of HAE Type I or Type II and according to the prescriber, the patient has had a favorable clinical response.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>CABLIVI</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, concurrent medications
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist
<b>Coverage Duration</b>	Approve for 12 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>CABOMETYX</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, histology, RET gene rearrangement status
<b>Age Restrictions</b>	Thyroid carcinoma-12 years and older

<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Renal Cell Carcinoma-Approve if the patient has relapsed or stage IV disease. 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, regorafenib or ripretinib. Bone cancer-approve if the patient has Ewing sarcoma or osteosarcoma and has tried at least one previous systemic regimen. Thyroid carcinoma-approve if the patient has differentiated thyroid carcinoma, patient is refractory to radioactive iodine therapy and the patient has tried a vascular endothelial growth factor receptor (VEGFR)-targeted therapy.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients with Non-Small Cell Lung Cancer with RET Gene Rearrangements, Gastrointestinal stromal tumors (GIST), Bone cancer
<b>CALQUENCE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	MCL, CLL and SLL-approve. Waldenstrom's Macroglobulinamia/Lymphoplasmacytic Lymphoma-approve if the patient has tried one prior therapy.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Waldenstrom's Macroglobulinamia/Lymphoplasmacytic Lymphoma.
<b>CAPRELSA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	MTC - approve. DTC - approve if refractory to radioactive iodine therapy.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma. Non-Small Cell Lung Cancer with RET Gene Rearrangements
<b>CARBAGLU</b>	

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a metabolic disease specialist or a specialist who focuses in the treatment of metabolic diseases
<b>Coverage Duration</b>	NAGS-Pt meets criteria no genetic test - 3 mo. Pt had genetic test - 12 mo, other-approve for 7 days
<b>Other Criteria</b>	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 than or equal to 50 micromol/L and the requested medication will be used in conjunction with other ammonia-lowering therapies.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) (generic carglumic acid)
<b>CAYSTON</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has has Pseudomonas aeruginosa in culture of the airway (e.g., sputum culture, oropharyngeal culture, bronchoalveolar lavage culture).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>CERDELGA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, lab test results
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	1 year

<b>Other Criteria</b>	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
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>CHEMET</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Blood lead level
<b>Age Restrictions</b>	Approve in patients between the age of 12 months and 18 years
<b>Prescriber Restrictions</b>	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)
<b>Coverage Duration</b>	Approve for 2 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>CHOLBAM</b>	
<b>Exclusion Criteria</b>	Combination Therapy with Chenodal
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with hepatologist, metabolic specialist, or GI
<b>Coverage Duration</b>	3 mos initial, 12 mos cont
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>CIBINQO</b>	

<b>Exclusion Criteria</b>	Concurrent use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD). Concurrent use with an Anti-Interleukin Monoclonal Antibody. Concurrent use with other Janus Kinase Inhibitors. Concurrent use with Xolair (omalizumab subcutaneous injection). Concurrent use with other potent immunosuppressants.
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	AD-18 years of age and older (initial therapy)
<b>Prescriber Restrictions</b>	Atopic Dermatitis-prescribed by or in consultation with an allergist, immunologist or dermatologist (initial therapy)
<b>Coverage Duration</b>	Initial-Atopic Dermatitis-3 months, Continuation-1 year
<b>Other Criteria</b>	Atopic Dermatitis, initial-approve if the patient has had a 3-month trial of at least one traditional systemic therapy OR patient has tried at least one traditional systemic therapy but was unable to tolerate a 3-month trial. Note: Examples of traditional systemic therapies include methotrexate, azathioprine, cyclosporine, and mycophenolate mofetil. A patient who has already tried Dupixent (dupilumab subcutaneous injection) or Adbry (tralokinumab-ldrm subcutaneous injection) is not required to step back and try a traditional systemic agent for atopic dermatitis. Continuation-Approve if the patient has been receiving Cibinqo for at least 90 days AND patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating Cibinqo) in at least one of the following: estimated body surface area affected, erythema, induration/papulation/edema, excoriations, lichenification, and/or a decreased requirement for other topical or systemic therapies for atopic dermatitis AND compared with baseline (prior to receiving Cibinqo), patient experienced an improvement in at least one symptom, such as decreased itching. Note: A patient who has received less than 3 months of therapy or who is restarting therapy with Cibinqo should be considered under initial therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>CIMZIA</b>	
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
<b>Required Medical Info</b>	Diagnosis, concurrent medications, previous therapies tried
<b>Age Restrictions</b>	18 years and older for CD and PP (initial therapy).
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	3 months initial, 1 year cont.

<b>Other Criteria</b>	AS initial tx, approve if the patient has tried TWO of the following drugs in the past: Enbrel, Humira, Xeljanz/XR, Taltz. PsA initial tx, approve if the patient has tried TWO of the following drugs in the past: Enbrel, Humira, Taltz, Stelara, Otezla, Orencia, Rinvoq, Skyrizi or Xeljanz/XR. RA initial tx, approve if the patient has tried two of the following drugs in the past: Enbrel, Humira, Orencia, Rinvoq or Xeljanz/XR. CD initial tx, approve if patient has previously tried Humira. Plaque Psoriasis (PP), initial tx-approve if the patient has tried TWO of the following drugs in the past: Enbrel, Humira, Skyrizi, Stelara SC, Otezla, or Taltz. Cont tx, AS/PsA/RA/CD/PP - approve if the pt had a response as determined by the prescriber. Non-radiographic axial spondylitis (nr-axSpA), initial tx-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 tx-approve if the patient has had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>CLOBAZAM</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, other medications tried
<b>Age Restrictions</b>	2 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist (initial therapy)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Dravet Syndrome and treatment-refractory seizures/epilepsy
<b>COMETRIQ</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.



<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Non-Small Cell Lung Cancer with RET Gene Rearrangements, Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma

### COPIKTRA

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, previous therapies
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Under CMS Review
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Under CMS Review

### COSENTYX

<b>Exclusion Criteria</b>	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
<b>Required Medical Info</b>	Diagnosis and previous medications use
<b>Age Restrictions</b>	PP initial-6 yrs and older.AS/Spondy initial - 18 yrs of age and older. PsA-2yr and older. Enthesitis related arthritis-4 years and older
<b>Prescriber Restrictions</b>	PP/PsA initial - prescribed by or in consultation with a dermatologist or rheumatologist. AS/spondylo/enthesitis initial-by or in consultation with rheumatologist
<b>Coverage Duration</b>	All dx initial - 3 months, cont tx 1 year
<b>Other Criteria</b>	PP initial-approve if the patient has tried TWO of the following drugs in the past: Enbrel, Humira, Skyrizi, Stelara SC, Otezla or Taltz (this criteria requirement only applies to patients 18 years and older). PsA (this requirement only applies to patients 18 years and older) initial-approve if the patient has tried TWO of the following drugs in the past: Enbrel, Humira, Skyrizi, Stelara SC, Otezla, Orencia, Xeljanz/XR, Rinvoq or Taltz. (Note: if the patient does not meet this requirement, previous trial(s) with the following drugs will be counted towards meeting the try TWO requirement: Cimzia, an infliximab product, golimumab SC/IV). AS initial-approve if the patient has tried TWO of the following drugs in the past: Enbrel, Humira, Xeljanz/XR or Taltz. Non-radiographic axial spondyloarthritis initial-approve if the patient has tried Taltz. Enthesitis-related arthritis-approve. Cont tx - approve if the pt has had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.

<b>Off-Label Uses</b>	
<b>COTELLIC</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Melanoma initial - must have BRAF V600 mutation.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Melanoma (unresectable, advanced or metastatic) - being prescribed in combination with Zelboraf. CNS Cancer-approve if the patient has BRAF V600 mutation-positive disease AND medication is being used for one of the following situations (i, ii, or iii): i) Adjuvant treatment of pilocytic astrocytoma or pleomorphic xanthoastrocytoma or ganglioglioma, OR ii) recurrent disease for low-grade glioma or anaplastic glioma or glioblastoma, OR iii) melanoma with brain metastases AND medication will be taken in combination with Zelboraf (vemurafenib tablets). Histiocytic Neoplasm-approve if the patient meets one of the following (i, ii, or iii): i) patient has Langerhans cell histiocytosis and one of the following: multisystem disease or pulmonary disease or central nervous system lesions, OR ii) patient has Erdheim Chester disease, OR iii) patient has Rosai-Dorfman disease AND patient has BRAF V600 mutation-positive disease.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Central Nervous System Cancer, Histiocytic Neoplasm
<b>CRESEMBA (ORAL)</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Candidiasis of the esophagus - HIV infection, sepsis
<b>CRINONE GEL</b>	
<b>Exclusion Criteria</b>	Use in patients to supplement or replace progesterone in the management of infertility.
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Secondary amenorrhea, 12 months.Support of an established pregnancy, 9 months.

<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Support of an established pregnancy
<b>CYSTEAMINE (OPHTHALMIC)</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an ophthalmologist or a metabolic disease specialist or specialist who focuses in the treatment of metabolic diseases
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has corneal cysteine crystal deposits confirmed by slit-lamp examination
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>CYSTEAMINE (ORAL)</b>	
<b>Exclusion Criteria</b>	Concomitant use of Cystagon and Procysbi
<b>Required Medical Info</b>	Diagnosis, genetic tests and lab results
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist or a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>DALFAMPRIDINE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	18 years and older (initial and continuation therapy)
<b>Prescriber Restrictions</b>	MS. If prescribed by, or in consultation with, a neurologist or MS specialist (initial and continuation).
<b>Coverage Duration</b>	Initial-4months, Continuation-1 year

<b>Other Criteria</b>	Initial-approve if the requested medication is being used to improve or maintain mobility in a patient with MS. Continuation-approve if the requested medication is being used to improve or maintain mobility in a patient with MS and the patient has responded to or is benefiting from therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>DALIRESP</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Chronic Obstructive Pulmonary Disease (COPD), medications tried.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	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).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>DAURISMO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, medications that will be used in combination, comorbidities
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	AML - approve if Daurismo will be used in combination with cytarabine.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients continuing Daurismo as post-induction therapy
<b>DEFERASIROX</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Serum ferritin level
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist
<b>Coverage Duration</b>	1 year

<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>DEFERIPRONE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Serum ferritin level
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Iron overload, chronic-transfusion related due to thalassemia syndrome or related to sickle cell disease or other anemias Initial therapy - approve. Continuation therapy - approve is the patient is benefiting from therapy as confirmed by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>DIACOMIT</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Documentation of diagnosis.
<b>Age Restrictions</b>	2 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an neurologist (initial therapy)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Dravet Syndrome-Initial therapy-approve if the patient is concomitantly receiving clobazam. Dravet Syndrome-Continuation-approve if the patient is responding to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>DIMETHYL FUMARATE</b>	
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS).
<b>Required Medical Info</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease

<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>DOPTELET</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, platelet count, date of procedure
<b>Age Restrictions</b>	18 years and older (for chronic ITP-initial therapy only)
<b>Prescriber Restrictions</b>	Chronic ITP-prescribed by or after consultation with a hematologist (initial therapy)
<b>Coverage Duration</b>	Thrombo w/chronic liver disease-5 days, chronic ITP-initial-3 months, cont-1 year
<b>Other Criteria</b>	Thrombocytopenia with chronic liver disease-Approve if the patient has a current platelet count less than 50 x 10 <sup>9</sup> /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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>DUPIXENT</b>	
<b>Exclusion Criteria</b>	Concurrent use with Xolair or another Anti-interleukin (IL) Monoclonal Antibody.
<b>Required Medical Info</b>	Diagnosis, prescriber specialty, other medications tried and length of trials
<b>Age Restrictions</b>	AD-6 months and older, asthma-6 years of age and older, Esophagitis-12 and older, Chronic Rhinosinusitis-18 and older
<b>Prescriber Restrictions</b>	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. Esophagitis-presc/consult-allergist or gastro
<b>Coverage Duration</b>	AD-Initial-4 mos, Cont-1 year, asthma/Rhinosinusitis/esophagitis-initial-6 months, cont 1 year

<b>Other Criteria</b>	<p>AD-Init-meets a and b: a.has used at least 1 medium, med-high, high, and/or super-high-potency rx top corticosteroid OR has AD affecting ONLY the face, eyes/eyelids, skin folds, and/or genitalia and has tried tacrolimus oint AND b.Inadequate efficacy demonstrated w/previously tried topical RX, according to prescribing physician.Cont-Approve if pt has responded as determined by the prescribing physician.Asthma-Init-approve if pt meets following (i, ii, and iii):i.Pt meets 1 of the following(a or b):a)blood eosinophil level greater than or equal to 150 cells per microliter within the previous 6 wks or within 6 wks prior to tx with any IL tx or Xolair OR b)has oral corticosteroid-dependent asthma, per the prescriber AND ii.has received at least 3 consecutive mos combo therapy with BOTH of the following (a and b): a)ICS AND b)At least 1 additional asthma controller/maintenance med(NOTE:exception to the requirement for a trial of 1 additional asthma controller/maintenance med can be made if patient has already received anti-IL-5 therapy or Xolair used concomitantly with an ICS for at least 3 consecutive mos. AND iii.asthma is uncontrolled or was uncontrolled prior to starting any anti-IL therapy or Xolair as defined by 1 of the following (a, b, c, d or e): a)experienced 2 or more asthma exacer requiring tx with systemic corticosteroids in the previous yr OR b)experienced 1 or more asthma exacer requiring hosp or an ED visit in the previous yr OR c)has a FEV1 less than 80% predicted OR d)has an FEV1/FVC less than 0.80 OR e)pt's asthma worsens upon tapering of oral corticosteroid tx.Cont-Approve if pt meets (i and ii): i.cont to receive tx with 1 ICS or 1 ICS-containing combo inhaler AND ii.has responded to Dupixent tx as determined by the prescribing physician.Chronic rhinosinusitis with Nasal Polyposis-Init-pt is currently receiving tx 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 1 of the following (a or b): a)has received tx w/syst corticosteroid within previous 2 yrs or has a contraindication to systemic corticosteroid tx OR b)has had prior surgery for nasal polyps. Cont-approve if pt cont to receive tx with an intranasal corticosteroid AND pt has responded to Dupixent tx as determined by the prescriber. Eosinophilic esophagitis, initial-approve if pt weighs greater than or equal to 40 kg, has dx of eosinophilic esophagitis confirmed by an endoscopic biopsy demonstrating greater than or equal to 15 intraepithelial eosinophils per high-power field, and does not have a secondary cause of eosinophilic esophagitis, and has received at least 8 wks of tx with a RX strength PPI. Cont-approve if pt has already received at least 6 mo of tx with Dupixent and pt has experienced reduced intraepithelial eosinophil count or decreased dysphagia/pain upon swallowing or reduced frequency/severity of food impaction.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>EMGALITY</b>	
<b>Exclusion Criteria</b>	Combination therapy with Aimovig, Vyepti or Ajovy
<b>Required Medical Info</b>	Diagnosis, number of migraine or cluster headaches per month, prior therapies tried
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	

<b>Coverage Duration</b>	Cluster headache tx-6 months, migraine prevention-1 year
<b>Other Criteria</b>	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 one standard prophylactic pharmacologic therapy (e.g., anticonvulsant, beta-blocker), and has had inadequate response 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ENBREL</b>	
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Info</b>	Diagnosis, concurrent medications, previous therapies tried.
<b>Age Restrictions</b>	PP-4 years and older (initial therapy)
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	FDA dx-6 mo init, 1 yr cont, Behcet's/uveitis init-6 mo, cont-12 mo.GVHD-3 mo



<b>Other Criteria</b>	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 systemic therapy for this condition (eg, MTX, sulfasalazine, leflunomide, NSAID), biologic 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-approve. 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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Graft versus host disease (GVHD), Behcet's disease, Uveitis
<b>EPCLUSA</b>	
<b>Exclusion Criteria</b>	Combination use with other direct acting antivirals, excluding ribavirin.
<b>Required Medical Info</b>	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
<b>Age Restrictions</b>	3 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
<b>Coverage Duration</b>	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Indications consistent with current AASLD/IDSA guidance

### EPIDIOLEX

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, previous therapies
<b>Age Restrictions</b>	Patients 1 year and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist (initial therapy)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Dravet Syndrome-approve if the patient has tried at least two other antiepileptic drugs or if the patient has tried Diacomit, Fintepla or clobazam. Lennox Gastaut Syndrome-approve if the patient has tried at least two other antiepileptics drugs or if the patient has tried one of lamotrigine, topiramate, Banzel, felbamate or clobazam. Tuberous Sclerosis Complex-approve if the patient has tried at least two other antiepileptic drugs. Continuation of therapy-approve if the patient is responding to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### EPOETIN ALFA

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	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, Mircerca 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
<b>Age Restrictions</b>	MDS anemia = 18 years of age and older
<b>Prescriber Restrictions</b>	MDS anemia, myelofibrosis- prescribed by or in consultation with, a hematologist or oncologist.
<b>Coverage Duration</b>	Chemo-6m,Transfus-1m, CKD-1yr, Myelofibrosis-init-3 mo, cont-1 yr, all others-1 yr
<b>Other Criteria</b>	Myelofibrosis-Initial-patient has a Hb less than 10 or serum erythropoietin less than or equal to 500 Mu/mL. Cont-approve if according to the prescriber the patient has had a response. Anemia in patients with chronic renal failure on dialysis - deny under Medicare Part D (claim should be submitted under the ESRD bundled payment benefit).
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Anemia due to myelodysplastic syndrome (MDS), Myelofibrosis

<b>ERIVEDGE</b>	
<b>Exclusion Criteria</b>	BCC (La or Met) - must not have had disease progression while on Odomzo.
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Central nervous System Cancer
<b>ERLEADA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ERLOTINIB</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Advanced, recurrent, or metastatic non small cell lung cancer (NSCLC), EGFR mutation or gene amplification status, pancreatic cancer.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.

<b>Other Criteria</b>	Advanced or Metastatic NSCLC, approve if the patient has sensitizing EGFR mutation positive non-small cell lung cancer as detected by an approved test. Note-Examples of sensitizing EGFR mutation-positive non-small cell lung cancer include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S768I. RCC, approve if the patient has recurrent or advanced non-clear cell histology RCC or if the patient had hereditary leiomyomatosis and renal cell carcinoma and erlotinib will be used in combination with bevacizumab. Bone cancer-approve if the patient has chordoma and has tried imatinib, dasatinib or sunitinib. Pancreatic cancer-approve if the medication is used in combination with gemcitabine. Vulvar cancer-approve if the patient has advanced, recurrent or metastatic disease.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Renal Cell Carcinoma, vulvar cancer and Bone Cancer-Chordoma.
<b>ESBRIET</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>EVEROLIMUS</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Breast Cancer-HER2 status, hormone receptor (HR) status.
<b>Age Restrictions</b>	Relapsed or refractory classical Hodgkin lymphoma-18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.

<b>Other Criteria</b>	<p>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.</p> <p>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.</p> <p>Thymomas and Thymic Carcinomas-approve if the patient has tried one prior chemotherapy (e.g., cisplatin plus doxorubicin, cisplatin plus etoposide, carboplatin plus paclitaxel).</p> <p>TSC-associated renal angiomyolipoma-approve.</p> <p>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.</p> <p>Endometrial Carcinoma-approve if everolimus will be used in combination with letrozole and the patient has recurrent, metastatic or high-risk disease.</p> <p>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.</p> <p>Tuberous sclerosis complex (TSC)-associated partial-onset seizures-approve.</p>
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	<p>Advanced, unresectable or metastatic neuroendocrine tumors of the thymus (Carcinoid tumors).Soft tissue sarcoma-Perivascular Epithelioid Cell Tumors (PEComa), Recurrent Angiomyolipoma, Lymphangioliomyomatosis, 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</p>

**EXKIVITY**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Non-Small Cell Lung Cancer (NSCLC)-approve if the patient meets (A, B and C): A) Patient has locally advanced or metastatic NSCLC AND B) Patient has epidermal growth factor receptor (EGFR) exon 20 insertion mutation, as determined by an approved test AND C) Patient has previously tried at least one platinum-based chemotherapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**EYSUVIS**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**FASENRA**

<b>Exclusion Criteria</b>	Concurrent use with Xolair or another Anti-Interleukin (IL) Monoclonal Antibody
<b>Required Medical Info</b>	Diagnosis, severity of disease, peripheral blood eosinophil count, previous therapies tried and current therapies, FEV1/FVC
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an allergist, immunologist, or pulmonologist
<b>Coverage Duration</b>	Authorization will be for 6 months initial, 12 months continuation.

<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>FINTEPLA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	2 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist (initial therapy)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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, clobazam or Diacomit. Dravet Syndrome-Continuation-approve if the patient is responding to therapy. Lennox-Gastaut Syndrome, initial-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs. Lennox-Gastaut Syndrome, continuation-approve if the patient is responding to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>FIRDAPSE</b>	
<b>Exclusion Criteria</b>	History of seizures (initial therapy)

<b>Required Medical Info</b>	Diagnosis, seizure history, lab and test results
<b>Age Restrictions</b>	18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or a neuromuscular specialist (initial therapy)
<b>Coverage Duration</b>	Initial-3 months, Cont-1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### FOTIVDA

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, other therapies
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### GATTEX

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	1 year and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist (initial and continuation)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.



<b>Off-Label Uses</b>	
<b>GAVRETO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	NSCLC-18 years and older, MTC/thyroid cancer-12 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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 metastatic rearranged during transfection (RET) fusion-positive disease, the disease is radioactive iodine-refractory AND the disease requires treatment with systemic therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>GILENYA</b>	
<b>Exclusion Criteria</b>	Concurrent use of Gilenya with other disease-modifying agents used for multiple sclerosis (MS).
<b>Required Medical Info</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>GILOTRIF</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	For NSCLC - EGFR exon deletions or mutations, or if NSCLC is squamous cell type
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.

<b>Other Criteria</b>	NSCLC EGFR pos - For the treatment of advanced or metastatic non small cell lung cancer (NSCLC)-approve if the patient has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note: examples of sensitizing EGFR mutation-positive NSCLC include the following mutations : exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S768I. NSCLC metastatic squamous cell must have disease progression with first line treatment with platinum based chemotherapy. Head and neck cancer-approve if the patient has non-nasopharyngeal head and neck cancer and the patient has disease progression on or after platinum based chemotherapy.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Head and neck cancer
<b>GLATIRAMER</b>	
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Info</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>GLUCAGON-LIKE PEPTIDE-1 AGONISTS</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>GONADOTROPIN-RELEASING HORMONE AGONISTS - INJECTABLE LONG ACTING</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	For the treatment of cancer diagnosis must be prescribed by or in consultation with an oncologist.

<b>Coverage Duration</b>	uterine leiomyomata approve 3months/all other dx 12 mo
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	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
<b>GRALISE/HORIZANT/LYRICA CR</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	
<b>GROWTH HORMONES</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	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
<b>Age Restrictions</b>	ISS 5 y/o or older, SGA 2 y/o or older, SBS 18 y/o or older

<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	ISS - 6 mos initial, 12 months cont tx, SBS 1 month, others 12 mos
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	CKD, SHOX, SBS
<b>HARVONI</b>	

<b>Exclusion Criteria</b>	Combination use with other direct acting antivirals, excluding ribavirin
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	3 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
<b>Coverage Duration</b>	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Indications consistent with current AASLD/IDSA guidance
<b>HETLIOZ</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Non-24-patient is totally blind with no perception of light
<b>Age Restrictions</b>	Non-24-18 years or older (initial and continuation), SMS-16 years and older
<b>Prescriber Restrictions</b>	prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of sleep disorders (initial and continuation)
<b>Coverage Duration</b>	6 mos initial, 12 mos cont
<b>Other Criteria</b>	Initial - patient is totally blind with no perception of light, 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 plus evaluation of sleep logs. Cont - Approve if patient is totally blind with no perception of light and 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>HIGH RISK MEDICATIONS - BENZODIAZEPINES</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Procedure-related sedation = 1mo. All other conditions = 12 months.

<b>Other Criteria</b>	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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	
<b>HIGH RISK MEDICATIONS - BENZTROPINE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	
<b>HIGH RISK MEDICATIONS - CYCLOBENZAPRINE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	Patients aged less than 65 years, approve.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	
<b>HIGH RISK MEDICATIONS - FIRST GENERATION ANTIHISTAMINES</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months.

<b>Other Criteria</b>	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 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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	
<b>HIGH RISK MEDICATIONS - PHENOBARBITAL</b>	
<b>Exclusion Criteria</b>	Coverage is not provided for use in sedation/insomnia.
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For the treatment of seizures, approve only if the patient is currently taking phenobarbital.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	
<b>HIGH RISK MEDICATIONS- ESTROGENS</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Previous medication use
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	
<b>HUMIRA</b>	
<b>Exclusion Criteria</b>	Concurrent use with another biologic DMARD or targeted synthetic DMARD.
<b>Required Medical Info</b>	Diagnosis, concurrent medications, previous therapies tried

<b>Age Restrictions</b>	Crohn's disease (CD), 6 or older (initial therapy only). Ulcerative colitis (UC) 5 or older (initial therapy only), PP-18 or older (initial therapy only)
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	initial 6 mo, cont tx 1 year
<b>Other Criteria</b>	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 one other systemic therapy for this condition (e.g MTX, sulfasalazine, leflunomide, NSAID) or biologic (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 conventional systemic therapy for CD (eg, azathioprine, 6-mercaptopurine, MTX, certolizumab, infliximab, ustekinumab, or vedolizumab) OR pt had ileocolonic 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>IBRANCE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	



<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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 or 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
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Liposarcoma
<b>ICATIBANT</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	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 percent 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ICLUSIG</b>	

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis the Philadelphia chromosome (Ph) status of the leukemia must be reported. T315I status
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Approve if the patient meets one of the following: 1. Patient has CML or ALL that is Ph+, T315I-positive or, 2. patient has CML, chronic phase with resistance or intolerance to at least two prior TKIs or, 3. patient has accelerated phase or blast phase CML or Philadelphia chromosome positive ALL for whom no other TKIs are indicated.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### IDH1FA

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	IDH2-mutation status
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	AML - approve if the patient is IDH2-mutation status positive as detected by an approved test
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### IMATINIB

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
<b>Age Restrictions</b>	ASM, DFSP, HES, MDS/MPD-18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	For ALL/CML, must have Ph-positive for approval of imatinib. Kaposi's Sarcoma-approve if the patient has tried at least one regimen AND has relapsed or refractory disease. Pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT)-patient has tried Turalio or according to the prescriber, the patient cannot take Turalio.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Chordoma, advanced, aggressive or unresectable fibromatosis (desmoid tumors), cKit positive advanced/recurrent or metastatic melanoma, Kaposi's Sarcoma and pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor.

<b>IMBRUVICA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	GVHD-1 year, all others-3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	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).
<b>IMPAVIDO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>INJECTABLE TESTOSTERONE PRODUCTS</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, lab results
<b>Age Restrictions</b>	Delayed puberty or induction of puberty in males-14 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Delayed puberty or induction of puberty in males-6 months, all others-12 months

<b>Other Criteria</b>	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
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>INLYTA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Advanced Renal cell carcinoma-approve. Differentiated thyroid cancer, approve if patient is refractory to radioactive iodine therapy.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma
<b>INQOVI</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**INREBIC**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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. Myeloid/Lymphoid Neoplasms with Eosinophilia-approve if the tumor has a JAK2 rearrangement.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Myeloid/Lymphoid Neoplasms with Eosinophilia

**IRESSA**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	NSCLC-approve if the patient has advanced or metastatic disease and the patient has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note: Examples of sensitizing EGFR mutation-positive NSCLC include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S768I
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**IVIG**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Part B versus D determination per CMS guidance to establish if drug used for PID in pt's home.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	

**JAKAFI**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	ALL-less than 21 years of age, GVHD-12 and older, MF/PV/CMML-2/essential thrombo/myeloid/lymphoid neoplasm-18 and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	GVHD/ALL-1 year, all others-3 years.
<b>Other Criteria</b>	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. Polycythemia vera-approve if the patient has tried hydroxyurea. 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. Essential thrombocythemia-approve if the patient has tried hydroxyurea, peginterferon alfa-2a or anagrelide. Myeloid/lymphoid neoplasms-approve if the patient has eosinophilia and the tumor has a janus associated kinase 2 (JAK2) rearrangement.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Acute lymphoblastic leukemia, atypical chronic myeloid leukemia, chronic monomyelocytic leukemia-2 (CMML-2), essential thrombocythemia, myeloid/lymphoid neoplasms

**JUXTAPID**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	12 months

<b>Other Criteria</b>	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) and had clinical manifestation of HoFH before the age of 10 years OR both parents of the patient had untreated LDL-C levels or total cholesterol levels consistent with HeFH OR the patient has a treated LDL-C level greater than or equal to 300 mg/dL and had clinical manifestation of HoFH before the age of 10 years OR both parents of the patient had untreated LDL-C levels or total cholesterol levels consistent with HeFH, AND 2) Patient has tried at least one PCSK9 inhibitor for greater than or equal to 8 continuous weeks and the LDL-C level after this PCSK9 inhibitor therapy remains greater than or equal to 70 mg/dL 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 after these treatment regimens 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>KALYDECO</b>	
<b>Exclusion Criteria</b>	Combination use with Orkambi, Trikafta or Symdeko
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	4 months of age and older
<b>Prescriber Restrictions</b>	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	CF - must have one mutation in the CFTR gene that is responsive to the requested medication.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>KISQALI</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years

<b>Other Criteria</b>	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 will be used in combination with anastrozole, exemestane or letrozole. 4. Patient is postmenopausal (patient receiving ovarian suppression/ablation with a GnRH agonist or has had surgical bilateral oophorectomy or ovarian irradiation) 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 or Verzenio 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>KORLYM</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, prior surgeries
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome
<b>Coverage Duration</b>	Endogenous Cushing's Synd-1 year. Patients awaiting surgery or response after radiotherapy-4 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients with Endogenous Cushing's Syndrome, awaiting surgery. Patients with Endogenous Cushing's syndrome, awaiting a response after radiotherapy
<b>KYNMOBI</b>	
<b>Exclusion Criteria</b>	



<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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 and experienced intolerance or inadequate efficacy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### LAPATINIB

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis for which lapatinib is being used. Metastatic breast cancer, HER2 status or hormone receptor (HR) status.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Bone cancer-chordoma, colon or rectal cancer

### LENVIMA

<b>Exclusion Criteria</b>	
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<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	DTC - must be refractory to radioactive iodine treatment for approval. RCC, advanced disease - approve if the pt meets i or ii:i. Lenvima is is being used in combination with pembrolizumab OR ii. Lenvima is used in combination with everolimus and the patient meets a or b-a. Patient has clear cell histology and patient has tried one antiangiogenic therapy or b. patient has non-clear cell histology. 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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients with Medullary Thyroid Carcinoma (MTC) and anaplastic thyroid carcinoma.
<b>LEUKINE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	Neuroblastoma-less than 18 years of age
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	Radiation Syndrome/BMT - 1 mo, AML/Neuroblastoma-6 months, PBPC-14 days
<b>Other Criteria</b>	Neuroblastoma-approve if the patient is receiving Leukine in a regimen with dinutuximab.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Neuroblastoma
<b>LIDOCAINE PATCH</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	

<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Diabetic neuropathic pain, chronic back pain

**LONG ACTING OPIOIDS**

<b>Exclusion Criteria</b>	Acute (ie, non-chronic) pain
<b>Required Medical Info</b>	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**LONSURF**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**LORBRENA**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, ALK status, ROS1 status, previous therapies
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	NSCLC - Approve if the patient has ALK-positive metastatic NSCLC, as detected by an approved test. NSCLC-ROS1 Rearrangement-Positive-approve if the patient has tried at least one of crizotinib, entrectinib or ceritinib.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Non-small cell lung cancer (NSCLC)-ROS1 Rearrangement-Positive

**LOTRONEX**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**LUMAKRAS**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years
<b>Other Criteria</b>	Non-Small Cell Lung Cancer (NSCLC)-approve if the patient has KRAS G12C-mutated locally advanced or metastatic NSCLC, as determined by an FDA-approved test AND has been previously treated with at least one systemic regimen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**LYNPARZA**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	18 years and older

<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	<p>Ovarian Cancer-Treatment-initial-Approve if pt meets the following criteria (i and ii): i.pt 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. Cont-approve if pt has a BRCA mutation (germline) as confirmed by an approved test. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer - Maintenance monotherapy-Approve if pt meets one of the following criteria (A or B): A)pt meets both of the following criteria for first-line maintenance therapy (i and ii): i.pt has a germline or somatic BRCA mutation-positive disease as confirmed by an approved test AND ii.pt 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)pt 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, combination therapy-approve if the medication is used in combination with bevacizumab, the patient has homologous recombination deficiency (HRD)-positive disease, as confirmed by an approved test and the patient is in complete or partial response to first-line platinum-based chemotherapy regimen. Breast Cancer-Approve if the pt meets the following criteria (A, B and C)-A.pt has metastatic, germline BRCA mutation-positive breast cancer AND B.pt meets ONE of the following criteria (i or ii)- i. pt meets BOTH of the following criteria (a and b)-a)pt has hormone receptor positive (HR+) [i.e., estrogen receptor positive ER+ and/or progesterone receptor positive PR+] disease AND b)pt meets ONE of the following criteria (1 or 2)-1-pt has been treated with prior endocrine therapy OR-2 pt is considered inappropriate for endocrine therapy OR ii. Pt has triple negative disease (i.e., ER-negative, PR-negative, and HER2-negative) AND C.pt 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 the pt has metastatic disease, the medication is used concurrently with a gonadotropin-releasing hormone (GnRH) analog or the pateint has had a bilateral orchiectomy, the patient has germline or somatic homologous recombination repair (HRR) gene-mutated disease, as confirmed by an approved test, the pt does not have a PPP2R2A mutation and the patient has been previously treated with at least one androgen receptor directed therapy. Uterine Leiomyosarcoma-approve if the patient has BRCA2-altered disease and has tried one systemic regimen.</p>
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Uterine Leiomyosarcoma
<b>MEGACE</b>	
<b>Exclusion Criteria</b>	Coverage is not provided for weight gain for cosmetic reasons.
<b>Required Medical Info</b>	

<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	

**MEKINIST**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis for which Mekinist is being used. For melanoma, thyroid cancer and NSCLC must have documentation of BRAF V600 mutations
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.

<b>Other Criteria</b>	<p>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 Tafenlar. Thyroid cancer, anaplastic-patient has locally advanced or metastatic anaplastic disease AND Mekinist will be taken in combination with Tafenlar, 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. Biliary Tract Cancer-approve if the patient has tried at least one systemic chemotherapy regimen, patient has BRAF V600 mutation positive disease and the medication will be taken in combination with Tafenlar. Central Nervous System Cancer-approve if the medication is being used for one of the following situations (i, ii, or iii): i) adjuvant treatment of one of the following conditions: pilocytic astrocytoma or pleomorphic xanthoastrocytoma or ganglioglioma, OR ii) recurrent disease for one of the following conditions: low-grade glioma OR anaplastic glioma OR glioblastoma, OR iii) melanoma with brain metastases AND patient has BRAF V600 mutation-positive disease AND medication will be taken in combination with Tafenlar (dabrafenib). Histiocytic neoplasm-approve if patient has Langerhans cell histiocytosis and one of the following: multisystem disease or pulmonary disease or central nervous system lesions or patient has Erdheim Chester disease or Rosai-Dorfman disease AND patient has BRAF V600-mutation positive disease.</p>
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<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Ovarian/Fallopian Tube/Primary Peritoneal Cancer, Biliary Tract Cancer, Central Nervous System Cancer, Histiocytic Neoplasm

**MEKTOVI**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, BRAF V600 status, concomitant medications
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### MEMANTINE

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Indication for which memantine is being prescribed.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients with mild to moderate vascular dementia.

### MIGLUSTAT

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### MODAFINIL/ARMODAFINIL

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	

<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	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).
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Excessive daytime sleepiness (EDS) associated with myotonic dystrophy - modafinil only. Adjunctive/augmentation for treatment of depression in adults - modafinil only.
<b>MULPLETA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, platelet count, date of procedure
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	7 days
<b>Other Criteria</b>	Approve if the patient has a current platelet count less than 50 x 10 <sup>9</sup> /L AND the patient is scheduled to undergo a procedure within 8 to 14 days after starting Mulpleta therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>MYALEPT</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an endocrinologist or a geneticist physician specialist
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>NATPARA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist.



<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>NAYZILAM</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, other medications used at the same time
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>NERLYNX</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Stage of cancer, HER2 status, previous or current medications tried
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Adjuvant tx-Approve for 1 year (total), advanced or metastatic disease-3yrs
<b>Other Criteria</b>	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, recurrent 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>NEXAVAR</b>	
<b>Exclusion Criteria</b>	

<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Under CMS Review
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	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
<b>NEXLETOL</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 1 year

<b>Other Criteria</b>	<p>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 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.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>NEXLIZET</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 1 year

<b>Other Criteria</b>	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 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.
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<b>Indications</b>	All FDA-approved Indications.
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<b>Off-Label Uses</b>	
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<b>NILUTAMIDE</b>
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<b>Exclusion Criteria</b>	
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<b>Required Medical Info</b>	Diagnosis
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<b>Age Restrictions</b>	
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<b>Prescriber Restrictions</b>	
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<b>Coverage Duration</b>	3 years
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<b>Other Criteria</b>	Prostate cancer-approve if nilutamide is used concurrently with a luteinizing hormone-releasing hormone (LHRH) agonist.
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<b>Indications</b>	All FDA-approved Indications.
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<b>Off-Label Uses</b>	
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<b>NINLARO</b>
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<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	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).
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients with systemic light chain amyloidosis, Waldenstrom Macroglobulinemia/lymphoplasmacytic lymphoma
<b>NITISINONE</b>	
<b>Exclusion Criteria</b>	Concomitant therapy with nitisinone products
<b>Required Medical Info</b>	Diagnosis, genetic tests and lab results
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>NIVESTYM</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.

<b>Coverage Duration</b>	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
<b>Other Criteria</b>	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 count less than 100 cells/mm <sup>3</sup> ], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	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).
<b>NON-INJECTABLE TESTOSTERONE PRODUCTS</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	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.]
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months.

<b>Other Criteria</b>	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.]
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>NORTHERA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Medication history
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>NUBEQA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>NUCALA</b>	

<b>Exclusion Criteria</b>	Concurrent use with Xolair or another Anti-Interleukin (IL) Monoclonal Antibody.
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	Asthma-6 years of age and older. EGPA/Polyps-18 years of age and older. HES-12 years and older.
<b>Prescriber Restrictions</b>	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. Polyps-prescribed by or in consult with allergist, immunologist or Otolaryngologist.
<b>Coverage Duration</b>	Initial-Asthma/EGPA/polyps-6 months, HES-8 months. 12 months continuation.
<b>Other Criteria</b>	Asthma initial-must have blood eosinophil level of greater than or equal to 150 cells per microliter within the prev 6 wks(prior to treatment with any anti-interleukin (IL)-5 therapy) AND Pt has received at least 3 consecutive mo of combo tx with an inhaled corticosteroid AND at least 1 additional asthma controller/maintenance med AND pt's asthma cont to be uncontrolled, or was uncontrolled prior to starting any anti-IL tx as defined by 1 of the following-pt exp 2 or more asthma exacerbations requiring tx with systemic corticosteroids in the prev yr, pt experienced 1 or more asthma exacerbation requiring hospital or an ED visit in the prev yr, pt has a FEV1 less than 80 percent predicted, Pt has an FEV1/FVC less than 0.80, or Pt's asthma worsens upon taper of oral corticosteroid tx.NOTE:An exception to the requirement for trial of 1 additional asthma controller/maintenance medication can be made if the pt has already received anti-IL-5 tx used concomitantly with an ICS for at least 3 consecutive mo. Cont-pt has responded to Nucala tx as determined by the prescribing physician AND Pt continues to receive tx with an inhaled corticosteroid. EGPA initial-pt has/had a blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6 wks or within 6 wks prior to tx with any anti-interleukin (IL)-5 therapy. Cont-pt has responded to Nucala tx as determined by the prescribing physician. HES initial-pt has had hypereosinophilic syndrome for greater than or equal to 6 mo AND has FIP1L1-PDGFRalpha-negative disease AND the pt does NOT have an identifiable non-hematologic secondary cause of hypereosinophilic syndrome AND prior to initiating tx with any anti-interleukin-5 tx, pt has/had a blood eosinophil level of greater than or equal to 1,000 cells per microliter.Cont-approve if pt has received at least 8 mo of tx with Nucala (patients who have received less than 8 mo of tx or who are restarting tx should be reviewed under initial tx) and pt has responded to Nucala tx. Nasal polyps, initial-approve if pt meets ALL of the following criteria(A, B, C and D):A) pt has chronic rhinosinusitis with nasal polyposis as evidenced by direct exam, endoscopy, or sinus CT scan AND B)pt has experienced 2 or more of the following symptoms for at least 6 mo:nasal congestion/obstruction/discharge, and/or reduction/loss of smell AND C)pt meets BOTH of the following (a and b): a)Pt has received at least 8 weeks of tx with intranasal corticosteroid AND b)Pt will cont to receive tx with an intranasal corticosteroid concomitantly with Nucala AND D)pt meets 1 of the following (a, b or c): a)Pt has received at least 1 course of tx with a systemic corticosteroid for 5 days or more within the previous 2 yrs, OR b)Pt has a contraindication to systemic corticosteroid therapy, OR c)Pt has had prior surgery for nasal polyps.Cont-approve if pt has received at least 6 mo of tx, continues to receive tx with an intranasal corticosteroid and has responded to tx.



<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>NUDEXTA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>NUPLAZID</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>NURTEC</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Migraine, Acute treatment-approve. Preventive treatment of episodic migraine-approve if the patient has greater than or equal to 4 but less than 15 migraine headache days per month (prior to initiating a migraine preventive medication and 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.
<b>Indications</b>	All FDA-approved Indications.

<b>Off-Label Uses</b>	
<b>NYVEPRIA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	Cancer pts receiving chemo-6 mo. PBPC-1 mo
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients undergoing PBPC collection and therapy
<b>OICALIVA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Prescriber specialty, lab values, prior medications used for diagnosis and length of trials
<b>Age Restrictions</b>	18 years and older (initial)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician (initial)
<b>Coverage Duration</b>	6 months initial, 1 year cont.

<b>Other Criteria</b>	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)).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>OCTREOTIDE INJECTABLE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	
<b>ODOMZO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	BCC - Must not have had disease progression while on Erivedge (vismodegib).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Metastatic BCC
<b>OFEV</b>	
<b>Exclusion Criteria</b>	

<b>Required Medical Info</b>	
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ONUREG</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>OPSUMIT</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	PAH WHO group, right heart catheterization results, WHO functional status, previous drugs tried
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 3 years

<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ORENCIA</b>	
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
<b>Required Medical Info</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	SC-6 mos initial, 1 year cont
<b>Other Criteria</b>	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). PsA, initial -approve. Juvenile idiopathic arthritis (JIA) [or Juvenile Rheumatoid Arthritis (JRA)], initial - 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ORGOVYX</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Prostate Cancer-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ORKAMBI</b>	
<b>Exclusion Criteria</b>	Combination use with Kalydeco, Trikafta or Symdeko.
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	2 years of age and older

<b>Prescriber Restrictions</b>	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ORLADEYO</b>	
<b>Exclusion Criteria</b>	Concomitant Use with Other HAE Prophylactic Therapies (e.g., Cinryze, Haegarda, Takhzyro).
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	12 years and older (initial and continuation)
<b>Prescriber Restrictions</b>	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)
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	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].
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>OTEZLA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, previous drugs tried
<b>Age Restrictions</b>	18 years and older (initial)
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	6 months initial, 1 year cont

<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>OXERVATE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an ophthalmologist or an optometrist.
<b>Coverage Duration</b>	2 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>PALYNZIQ</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, phenylalanine concentrations
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases
<b>Coverage Duration</b>	1 year (initial and continuation)
<b>Other Criteria</b>	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 has experienced improvement while on Palynziq.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>PANRETIN</b>	
<b>Exclusion Criteria</b>	

<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist, oncologist, or infectious disease specialist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Kaposi Sarcoma-approve if the patient is not receiving systemic therapy for Kaposi Sarcoma.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>PEMAZYRE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, prior therapies
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years
<b>Other Criteria</b>	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
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>PENICILLAMINE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Wilson's Disease-Prescribed by or in consultation with a gastroenterologist, hepatologist or liver transplant physician
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>PHENYLBUTYRATE</b>	
<b>Exclusion Criteria</b>	Concomitant use of Ravicti and Buphenyl
<b>Required Medical Info</b>	Diagnosis, genetic tests and lab results
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)



<b>Coverage Duration</b>	Pt meets criteria with no genetic test - 3 mo approval. Pt had genetic test - 12 mo approval
<b>Other Criteria</b>	Urea cycle disorders-approve if genetic testing confirmed a mutation resulting in a urea cycle disorder or if the patient has hyperammonemia.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>PHEOCHROMOCYTOMA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, prior medication trials
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the management of pheochromocytoma (initial and continuation therapy for metyrosine)
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	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). If the requested drug is metyrosine for continuation therapy, approve if the patient is currently receiving metyrosine or has received metyrosine in the past.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>PHOSPHODIESTERASE-5 INHIBITORS FOR PAH</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, right heart cath results
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	For PAH, if prescribed by, or in consultation with, a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>PIQRAY</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, prior therapies
<b>Age Restrictions</b>	

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<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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 or has had surgical bilateral oophorectomy or ovarian irradiation 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, tamoxifen, toremifene) AND F) Piqray will be used in combination with fulvestrant injection.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Treatment of breast cancer in premenopausal women
<b>PLEGRIDY</b>	
<b>Exclusion Criteria</b>	Concurrent use of with other disease-modifying agents used for multiple sclerosis (MS).
<b>Required Medical Info</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>POMALYST</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	Kaposi Sarcoma/MM-18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years
<b>Other Criteria</b>	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). MM-approve if the patient has received at least one other Revlimid (lenalidomide tablets)-containing regimen.

<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Systemic Light Chain Amyloidosis, Central Nervous System (CNS) Lymphoma
<b>POSACONAZOLE (ORAL)</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Aspergillus/Candida prophylaxis, mucormycosis-6 mo, all others-3 months
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	esophageal candidiasis - treatment, mucormycosis - maintenance, fusariosis, invasive - treatment fungal infections (systemic) in patients with human immunodeficiency virus (HIV) infections (e.g., histoplasmosis, coccidioidomycosis) - treatment.
<b>PROLIA</b>	
<b>Exclusion Criteria</b>	Concomitant use with other medications for osteoporosis
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 1 year.

<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>PROMACTA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Cause of thrombocytopenia. Thrombocytopenia due to HCV-related cirrhosis, platelet counts. Severe aplastic anemia, platelet counts and prior therapy. MDS-platelet counts.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Immune Thrombocytopenia 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).
<b>Coverage Duration</b>	Immune Thrombo/MDS initial-3 mo, cont 1yr, AA-initial-4 mo, cont-1 yr, Thrombo/Hep C-1 yr

<b>Other Criteria</b>	Thrombocytopenia in patients with immune thrombocytopenia, 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 mofetil, 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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Thrombocytopenia in Myelodysplastic Syndrome (MDS)
<b>PYRIMETHAMINE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Patient's immune status
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Toxoplasma gondii Encephalitis, Chronic Maintenance, approve if the patient is immunosuppressed. Toxoplasma gondii Encephalitis Prophylaxis (Primary), approve if the patient is immunosuppressed.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Chronic maintenance and prophylaxis of Toxoplasma Gondii encephalitis
<b>QINLOCK</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, other therapies tried
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years

<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### REPATHA

<b>Exclusion Criteria</b>	Concurrent use of Juxtapid or Praluent.
<b>Required Medical Info</b>	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
<b>Age Restrictions</b>	ASCVD/Primary Hyperlipidemia - 18 yo and older, HoFH/HeFH - 10 yo and older.
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	Approve for 1 year

<b>Other Criteria</b>	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 rosuvastatin 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 rosuvastatin 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).
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<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### RETEVMO

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	Medullary Thyroid Cancer/Thyroid Cancer-12 years and older, all others 18 years and older

<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Anaplastic thyroid carcinoma
<b>REVCOVI</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, lab values, genetic tests
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with, an immunologist, hematologist/oncologist, or physician that specializes in ADA-SCID or related disorders.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	ADA-SCID - approve if the patient had absent or very low (less than 1% of normal) ADA catalytic activity at baseline (i.e., prior to initiating enzyme replacement therapy) OR if the patient had molecular genetic testing confirming bi-allelic mutations in the ADA gene
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>REVLIMID</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis and previous therapies or drug regimens tried.
<b>Age Restrictions</b>	18 years and older (except Kaposi's Sarcoma, Castleman's Disease, CNS Lymphoma)
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.

<b>Other Criteria</b>	<p>Follicular lymphoma-approve if the patient is using Revlimid in combination with rituximab or has tried at least on prior therapy. MCL-approve if the patient is using revlimid in combination with rituximab or has tried at least two other therapies or therapeutic regimens. MZL-approve if the patient is using revlimid in combination with rituximab or has tried at least one other therapy or therapeutic regimen. 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]). B-cell-lymphoma (other)-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 or according to the prescriber the patient has anemia, has serum erythropoietin levels less than 500 mU/mL and patient has experienced no response or loss of response to erythropoietic stimulating agents. Peripheral T-Cell Lymphoma or T-Cell Leukemia/Lymphoma-approve if the pt has tried at least one other therapy or regimen. CNS lymphoma-approve if according to the prescriber the patient has relapsed or refractory disease. Hodgkin lymphoma, classical-approve if the patient tried at least one other therapy or therapeutic regimen. Castleman's disease-approve if the patient has relapsed/refractory or progressive disease. Kaposi's Sarcoma-approve if the patient has tried at least one regimen or therapy and the patient has relapsed or refractory disease. Systemic light chain amyloidosis-approve if Revlimid is used in combination with dexamethasone.</p>
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	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 lymphoma, Kaposi's sarcoma.
<b>RILUZOLE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist, a neuromuscular disease specialist, or a physician specializing in the treatment of ALS.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>RINVOQ</b>	



<b>Exclusion Criteria</b>	Concurrent use with a biologic or with a targeted synthetic DMARD. Concurrent use with other potent immunosuppressants.
<b>Required Medical Info</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	PsA/RA/UC/AS-18 years and older (initial therapy), AD-12 years and older (Initial therapy)
<b>Prescriber Restrictions</b>	RA/AS, prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or a dermatologist. AD-prescr/consult with allergist, immunologist or dermatologist. UC-prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	Authorization will be for 6 months initial, 1 year cont.
<b>Other Criteria</b>	RA/PsA/UC/AS initial-approve if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. AD-approve if the patient has had a 3 month trial of at least one traditional systemic therapy or has tried at least one traditional systemic therapy but was unable to tolerate a 3 month trial. Note: Examples of traditional systemic therapies include methotrexate, azathioprine, cyclosporine, and mycophenolate mofetil. A patient who has already tried Dupixent (dupilumab subcutaneous injection) or Adbry (tralokinumab-ldm subcutaneous injection) is not required to step back and try a traditional systemic agent for atopic dermatitis. Continuation Therapy - Patient must have responded, as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ROZLYTREK</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	Solid Tumors-12 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>RUBRACA</b>	
<b>Exclusion Criteria</b>	

<b>Required Medical Info</b>	Diagnosis for which Rubraca is being used. BRCA-mutation (germline or somatic) status. Other medications tried for the diagnosis provided
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### RUFINAMIDE

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	Patients 1 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Initial therapy-approve if rufinamide is being used for adjunctive treatment. Continuation-approve if the patient is responding to therapy
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Treatment-Refractory Seizures/Epilepsy

### RYDAPT

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	For AML, FLT3 status
<b>Age Restrictions</b>	18 years and older

<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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 Neoplasms with eosinophilia-approve if the patient has an FGFR1 rearrangement or has an FLT3 rearrangement.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Myeloid or lymphoid Neoplasms with eosinophilia
<b>SAPROPTERIN</b>	
<b>Exclusion Criteria</b>	Concurrent use with Palynziq (continuation only)
<b>Required Medical Info</b>	Diagnosis, Phe concentration
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases (initial therapy)
<b>Coverage Duration</b>	Initial-12 weeks, Continuation-1 year
<b>Other Criteria</b>	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 percent or greater reduction in blood Phe concentration from baseline OR treatment with sapropterin has resulted in an increase in dietary phenylalanine tolerance.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>SCSEMBLIX</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years

<b>Other Criteria</b>	Chronic Myeloid Leukemia (CML)-approve if the patient meets the following (A and B): A) Patient has Philadelphia chromosome-positive chronic myeloid leukemia, AND B) Patient meets one of the following (i or ii): i. The chronic myeloid leukemia is T315I-positive, OR ii. Patient has tried at least two other tyrosine kinase inhibitors indicated for use in Philadelphia chromosome-positive chronic myeloid leukemia. Note: Examples of tyrosine kinase inhibitors include imatinib tablets, Bosulif (bosutinib tablets), Iclusig (ponatinib tablets), Sprycel (dasatinib tablets), and Tassigna (nilotinib capsules).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>SENSIPAR</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hypercalcemia d/t parathyroid CA-prescr/consult w/onco or endo. Hypercalcemia w/primary hyperparathyroidism-prescr/consult w/nephro or endo. Hyperparathyroidism in post-renal transplant-prescr/consult w/transplant physician/nephro/endo.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Hypercalcemia due to parathyroid carcinoma-approve. Hypercalcemia in patients with primary hyperparathyroidism-approve if the patient has failed or is unable to undergo a parathyroidectomy due to a contraindication. Secondary Hyperparathyroidism in patients with chronic kidney disease on dialysis - deny under Medicare Part D (claim should be submitted under the ESRD bundles payment benefit). Hyperparathyroidism in Post-Renal Transplant Patients-approve if the baseline (prior to starting cinacalcet therapy) calcium and intact parathyroid hormone (iPTH) levels are above the normal range, as defined by the laboratory reference values.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	hyperparathyroidism in post-renal transplant patients
<b>SIGNIFOR</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or a physician or specializes in the treatment of Cushing's syndrome (initial therapy)
<b>Coverage Duration</b>	Cushing's-Initial-4 mo, Cont therapy-1 yr. Pt awaiting surgery or response after radiotherapy-4 mo

<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**SIMPONI**

<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
<b>Required Medical Info</b>	Diagnosis, concurrent medications, previous therapies tried.
<b>Age Restrictions</b>	UC-18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	3 mos initial, 1 year cont
<b>Other Criteria</b>	AS, initial -approve if the patient has tried TWO of the following drugs in the past: Enbrel, Humira, Xeljanz/XR, Taltz. PsA, initial-approve if the patient has tried TWO of the following drugs in the past: Enbrel, Humira, Taltz, Stelara, Otezla, Orencia, Rinvoq, Skyrizi, Xeljanz/XR. RA, initial- approve if the patient has tried two of the following drugs in the past: Enbrel, Humira, Orencia, Rinvoq or Xeljanz/XR. Ulcerative colitis, initial - approve if the patient has had a trial with Humira. Continuation tx - approve if the pt had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**SIRTURO**

<b>Exclusion Criteria</b>	Patients weighing less than 15 kg
<b>Required Medical Info</b>	Diagnosis, concomitant therapy
<b>Age Restrictions</b>	Patients 5 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with an infectious diseases specialist
<b>Coverage Duration</b>	9 months
<b>Other Criteria</b>	Tuberculosis, Pulmonary Multidrug-resistant or extensively drug resistant-prescribed as part of a combination regimen with other anti-tuberculosis agents
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**SKYRIZI**

<b>Exclusion Criteria</b>	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
<b>Required Medical Info</b>	Diagnosis, Previous medication use
<b>Age Restrictions</b>	18 years of age and older (initial therapy)
<b>Prescriber Restrictions</b>	PP-Prescribed by or in consultation with a dermatologist (initial therapy), PsA-prescribed by or in consultation with a rheumatologist or dermatologist (initial therapy), CD-presc/consult-gastro
<b>Coverage Duration</b>	6 mos initial, 1 year cont
<b>Other Criteria</b>	<p>PP-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.</p> <p>Continuation Therapy - Patient must have responded, as determined by the prescriber. Psoriatic arthritis (initial)-approve. Continuation-patient must have responded as determined by the prescriber. CD, initial-approve if the patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated or if the patient has tried one other conventional systemic therapy for CD (Please note: Examples of conventional systemic therapy for Crohn's disease include azathioprine, 6-mercaptopurine, or methotrexate. An exception to the requirement for a trial of or contraindication to steroids or a trial of one other conventional systemic agent can be made if the patient has already tried at least one biologic other than the requested medication. A biosimilar of the requested biologic does not count. A trial of mesalamine does not count as a systemic agent for Crohn's disease.) or if the patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas or if the patient had ileocolonic resection (to reduce the chance of CD recurrence). Patients must be receiving an induction dosing with Skyrizi IV within 3 month of initiating therapy with Skyrizi subcutaneous. Continuation-patient must have responded as determined by the prescriber.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>SOLARAZE</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	

<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 6 months.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**SOMAVERT**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, previous therapy, concomitant therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**SPRYCEL**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis for which Sprycel is being used. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
<b>Age Restrictions</b>	GIST-18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	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 - approve if the patient has tried at least two other therapies.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	GIST, chondrosarcoma, chordoma

**STELARA**

<b>Exclusion Criteria</b>	Ustekinumab should not be given in combination with a Biologic DMARD or Targeted Synthetic DMARD
<b>Required Medical Info</b>	Diagnosis, concurrent medications, previous drugs tried.

<b>Age Restrictions</b>	18 years and older CD/UC (initial therapy). PP-6 years and older (initial therapy).
<b>Prescriber Restrictions</b>	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).
<b>Coverage Duration</b>	PP/PsA Init-6mo,CD/UC load-approve 1 dose IV,CD/UC post IV load-SC 6 mo,cont tx-SC 1 yr
<b>Other Criteria</b>	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 conventional systemic therapy for CD (eg, azathioprine, 6-MP, MTX, certolizumab, vedolizumab, adalimumab, infliximab) OR 3) patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR 4) patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence). 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.PP initial - approve Stelara SC. CD, initial therapy - 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 conventional systemic therapy for CD OR 3) patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR 4) patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence). UC, initial therapy-approve SC if the patient received a single IV loading dose within 2 months of initiating therapy with Stelara SC. PP/PsA/CD/UC cont - approve Stelara SC if according to the prescribing physician, the patient has responded to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>STIVARGA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis for which Stivarga is being used. Prior therapies tried. For metastatic CRC, KRAS/NRAS mutation status.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.



<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Soft tissue Sarcoma, Osteosarcoma
<b>SUCRAID</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>SUTENT</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.

<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	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.
<b>SYMDEKO</b>	
<b>Exclusion Criteria</b>	Patients with unknown CFTR gene mutations, Combination therapy with Orkambi, Kalydeco or Trikafta
<b>Required Medical Info</b>	Diagnosis, specific CFTR gene mutations
<b>Age Restrictions</b>	Six years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>SYMLIN</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>SYNAREL</b>	
<b>Exclusion Criteria</b>	

<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	Endometriosis-18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Central Precocious Puberty-12 months, Endometriosis-6 months
<b>Other Criteria</b>	Central precocious puberty-approve. Endometriosis-approve if the patient has tried one of the following, unless contraindicated, a contraceptive, an oral progesterone or a depo-medroxyprogesterone injection. Note: An exception to the requirement for a trial of the above therapies can be made if the patient has previously used a gonadotropin-releasing hormone (GnRH) agonist or antagonist for endometriosis.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### TABRECTA

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	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 or high-level MET amplification, as detected by an approved test.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Non-small cell lung cancer with high-level MET amplification.

### TAFAMIDIS

<b>Exclusion Criteria</b>	Concomitant use with Onpattro or Tegsedi. Concurrent use of Vyndaqel and Vyndamax.
<b>Required Medical Info</b>	Diagnosis, genetic tests and lab results
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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).
<b>Indications</b>	All FDA-approved Indications.

<b>Off-Label Uses</b>	
<b>TAFINLAR</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis for which Tafinlar is being used. BRAF V600 mutations
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	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. Biliary Tract Cancer-approve if the patient has tried at least one systemic chemotherapy regimen, patient has BRAF V600 mutation positive disease and the medication will be taken in combination with Mekinist. Central Nervous System Cancer-approve if the medication is being used for one of the following situations (i, ii, or iii): i) adjuvant treatment of pilocytic astrocytoma OR pleomorphic xanthoastrocytoma OR ganglioglioma, OR ii) recurrent disease for one of the following: low-grade glioma OR anaplastic glioma OR glioblastoma, OR iii) melanoma with brain metastases AND patient has BRAF V600 mutation-positive disease AND medication will be taken in combination with Mekinist (trametinib tablets). Histiocytic neoplasm-approve if patient has Langerhans cell histiocytosis and one of the following: multisystem disease OR pulmonary disease OR central nervous system lesions OR patient has Erdheim Chester disease AND patient has BRAF V600-mutation positive disease.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients with Differentiated Thyroid Cancer, Biliary tract cancer, central nervous system cancer, histiocytic neoplasm
<b>TAGRISO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years

<b>Other Criteria</b>	NSCLC-EGFR Mutation Positive (other than EGFR T790M-Positive Mutation)- approve if the patient has advanced or metastatic disease, has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note-examples of sensitizing EGFR mutation-positive NSCLC include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S7681. NSCLC-EGFR T790M mutation positive-approve if the patient has metastatic EGFR T790M mutation-positive NSCLC as detected by an approved test and has progressed on treatment with at least one of the EGFR tyrosine kinase inhibitors. NSCLC-Post resection-approve if the patient has received previous adjuvant chemotherapy or if the patient is ineligible to receive platinum based chemotherapy and the patient has EGFR exon 19 deletions or exon 21 L858R substitution mutations, as detected by an approved test.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>TALTZ</b>	
<b>Exclusion Criteria</b>	Concurrent use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
<b>Required Medical Info</b>	Diagnosis, Previous medication use
<b>Age Restrictions</b>	PP-6 years and older (initial therapy), all other dx-18 years of age and older (initial therapy)
<b>Prescriber Restrictions</b>	All dx initial therapy only-PP-Prescribed by or in consultation with a dermatologist. PsA prescribed by or in consultation with a rheumatologist or a dermatologist. AS/spondylo -prescribed by or in consultation with a rheum.
<b>Coverage Duration</b>	Initial authorization will be for 6 months, 1 year continuation.
<b>Other Criteria</b>	Initial Therapy - Plaque Psoriasis-approve if the patient has tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant OR the patient has a contraindication to methotrexate (MTX), as determined by the prescribing physician. 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. PsA Initial-Approve. AS initial-approve. Non-Radiographic Axial Spondyloarthritis-approve if the patient has objective signs of inflammation, defined as at least one of the following: C-reactive protein elevated beyond the upper limit of normal for the reporting laboratory or sacroiliitis reported on magnetic resonance imaging. Continuation Therapy - approve if the patient has responded, as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>TALZENNA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, BRCA mutation status, HER2 status
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	

<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>TARGRETIN TOPICAL</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, previous therapies tried
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>TASIGNA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	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.
<b>Age Restrictions</b>	ALL/GIST-18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For CML, new patient must have Ph-positive CML for approval of Tasigna. For GIST, patient must have tried TWO or more therapies. 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).
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Philadelphia positive Acute Lymphoblastic Leukemia (ALL) and Gastrointestinal Stromal Tumor (GIST).
<b>TAZAROTENE</b>	
<b>Exclusion Criteria</b>	Cosmetic uses
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year

<b>Other Criteria</b>	Acne vulgaris after a trial with at least 1 other topical retinoid product (eg, tretinoin cream/gel/solution/microgel, adapalene).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	
<b>TAZVERIK</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	Epithelioid Sarcoma-16 years and older, Follicular Lymphoma-18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Epithelioid 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>TEPMETKO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	NSCLC-approve if the patient has metastatic disease and the tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutations or patient has high-level MET amplification, as detected by an approved test.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Non-small cell lung cancer with high-level MET amplification.
<b>TERIPARATIDE</b>	
<b>Exclusion Criteria</b>	Concomitant use with other medications for osteoporosis
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	2 years

<b>Other Criteria</b>	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.
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<b>Indications</b>	All FDA-approved Indications.
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<b>Off-Label Uses</b>	
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<b>TETRABENAZINE</b>	
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<b>Exclusion Criteria</b>	
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<b>Required Medical Info</b>	
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<b>Age Restrictions</b>	18 years and older
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<b>Prescriber Restrictions</b>	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.
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<b>Coverage Duration</b>	Authorization will be for 1 year.
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<b>Other Criteria</b>	Chorea associated with Huntington's Disease-approve if the diagnosis of Huntington's Disease is confirmed by genetic testing.
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<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
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<b>Off-Label Uses</b>	Tardive dyskinesia (TD). Tourette syndrome and related tic disorders. Hyperkinetic dystonia. Hemiballism.
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<b>THALOMID</b>	
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<b>Exclusion Criteria</b>	
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<b>Required Medical Info</b>	
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<b>Age Restrictions</b>	MM, myelofibrosis-18 years and older
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<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	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). 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, and is negative for the human immunodeficiency virus (HIV) and human herpesvirus-8 (HHV-8).
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Discoid lupus erythematosus or cutaneous lupus erythematosus, Myelofibrosis, Prurigo nodularis, Recurrent aphthous ulcers or aphthous stomatitis, Kaposi's Sarcoma, Castleman's Disease.
<b>TIBSOVO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, IDH1 Status
<b>Age Restrictions</b>	All diagnoses (except chondrosarcoma)-18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Chondrosarcoma
<b>TOLVAPTAN</b>	
<b>Exclusion Criteria</b>	Concurrent use with Jynarque.

<b>Required Medical Info</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 30 days
<b>Other Criteria</b>	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 tolvaptan and has received less than 30 days of therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>TOPICAL AGENTS FOR ATOPIC DERMATITIS</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	
<b>TOPICAL RETINOID PRODUCTS</b>	
<b>Exclusion Criteria</b>	Coverage is not provided for cosmetic use.
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	
<b>TOPIRAMATE/ZONISAMIDE</b>	
<b>Exclusion Criteria</b>	Coverage is not provided for weight loss or smoking cessation.

<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	
<b>TRANSDERMAL FENTANYL</b>	
<b>Exclusion Criteria</b>	Acute (i.e., non-chronic) pain.
<b>Required Medical Info</b>	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>TRANSMUCOSAL FENTANYL DRUGS</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 12 months.

<b>Other Criteria</b>	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.
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<b>Indications</b>	All FDA-approved Indications.
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<b>Off-Label Uses</b>	
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<b>TRIENTINE</b>	
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<b>Exclusion Criteria</b>	
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<b>Required Medical Info</b>	Diagnosis, medication history, pregnancy status, disease manifestations
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<b>Age Restrictions</b>	
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<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician.
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<b>Coverage Duration</b>	Authorization will be for 1 year
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<b>Other Criteria</b>	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, OR 6) the patient has been started on therapy with trientine.
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<b>Indications</b>	All FDA-approved Indications.
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<b>Off-Label Uses</b>	
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<b>TRIKAFTA</b>	
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<b>Exclusion Criteria</b>	Patients with unknown CFTR gene mutations. Combination therapy with Orkambi, Kalydeco or Symdeko.
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<b>Required Medical Info</b>	Diagnosis, specific CFTR gene mutations, concurrent medications
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<b>Age Restrictions</b>	Six years of age and older
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<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
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<b>Coverage Duration</b>	3 years
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<b>Other Criteria</b>	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.
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<b>Indications</b>	All FDA-approved Indications.
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<b>Off-Label Uses</b>	
<b>TRUSELTIQ</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Cholangiocarcinoma-approve if the patient has unresectable locally advanced or metastatic disease, has fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement, as detected by an approved test and Truseltiq will be used as subsequent therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>TUKYSA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, prior therapies
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>TURALIO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Tenosynovial Giant Cell Tumor (Pigmented Villonodular Synovitis)- approve if, according to the prescriber, the tumor is not amenable to improvement with surgery. Histiocytic Neoplasms-approve if the patient has a colony stimulating factor 1 receptor (CSF1R) mutation AND has one of the following conditions (i, ii, or iii): i. Langerhans cell histiocytosis OR ii. Erdheim-Chester disease OR iii. Rosai-Dorfman disease.

<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Histiocytic Neoplasms
<b>UBRELVY</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Migraine, Acute treatment-approve
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>UPTRAVI</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Confirmation of right heart catheterization, medication history.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PAH must be prescribed by, or in consultation with, a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>VALCHLOR</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years

<b>Other Criteria</b>	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. Langerhans cell histiocytosis-approve if the patient has unifocal Langerhans cell histiocytosis with isolated skin disease.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Adults with T-cell leukemia/lymphoma, Langerhans Cell Histiocytosis
<b>VALTOCO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, other medications used at the same time
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>VANCOMYCIN</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	2 weeks
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>VENCLEXTA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, prior therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years

<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Mantle Cell Lymphoma
<b>VERZENIO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	HR status, HER2 status, previous medications/therapies tried, concomitant therapy, menopausal status
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Breast cancer, early-approve for 2 years, all other-3 years



<b>Other Criteria</b>	<p>Breast Cancer, Early-Approve if pt meets (A,B,C and D): A)Pt has HR+ disease, AND B)Pt has HER2-negative breast cancer, AND C)Pt meets the following:Pt has node-positive disease at high risk of recurrence (Note-High risk includes patients with greater than or equal to 4 positive lymph nodes, or 1-3 positive lymph nodes with one or more of the following: Grade 3 disease, tumor size greater than or equal to 5 cm, or a Ki-67 score of greater than or equal to 20%) AND D)Pt meets ONE of the following (i or ii): i.Verzenio will be used in combo w/anastrozole, exemestane, or letrozole AND pt meets one of the following (a,b, or c): a)Pt is a postmenopausal woman, OR b)Pt is a pre/perimenopausal woman and meets one of the following 1 or 2:1-Pt is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist, OR 2-Pt has had surgical bilateral oophorectomy or ovarian irradiation, OR c)Pt is a man and pt is receiving a GnRH analog, OR ii.Verzenio will be used in combo with tamoxifen AND pt meets one of the following (a or b): a)Pt is a postmenopausal woman or man OR b)Pt is a pre/perimenopausal woman and meets one of the following 1 or 2:1-Pt is receiving ovarian suppression/ablation with a GnRH agonist, OR 2-Patient has had surgical bilateral oophorectomy or ovarian irradiation. Breast Cancer-Advanced or Metastatic in Women-Approve if pt meets (A, B, C and D): A) Pt has HR+ disease, AND B)Pt has HER2-negative breast cancer, AND C)Pt meets ONE of the following criteria (i or ii): i.Pt is a postmenopausal woman, OR ii.Pt is a pre/perimenopausal woman and meets one of the following (a or b): a)Pt is receiving ovarian suppression/ablation with a GnRH agonist, OR b)Pt has had surgical bilateral oophorectomy or ovarian irradiation, AND D)Pt meets ONE of the following criteria (i, ii, or iii): i.Verzenio will be used in combo with anastrozole, exemestane, or letrozole, OR ii.Verzenio will be used in combo with fulvestrant, OR iii.pt meets the following conditions (a, b, and c): a)Verzenio will be used as monotherapy, AND b)Pt's breast cancer has progressed on at least one prior endocrine therapy, AND c)Pt has tried chemotherapy for metastatic breast cancer.Breast Cancer-Advanced or Metastatic in Men-Approve if pt meets the following criteria (A,B and C): A)Pt has HR+ disease, AND B)Pt has HER2-negative breast cancer, AND C)Pt meets ONE of the following criteria (i, ii, or iii): i.Pt meets BOTH of the following conditions (a and b): a)Pt is receiving a GnRH analog, AND b)Verzenio will be used in combo with anastrozole, exemestane, or letrozole, OR ii.Verzenio will be used in combo with fulvestrant, OR iii.Pt meets the following conditions (a, b, and c): a)Verzenio will be used as monotherapy, AND b)Pt's breast cancer has progressed on at least one prior endocrine therapy, AND c)Pt has tried chemotherapy for metastatic breast cancer.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>VITRAKVI</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, NTRK gene fusion status
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	

<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>VIZIMPRO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, EGFR status, exon deletions or substitutions
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	NSCLC-approve if the patient has advanced or metastatic disease and has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note: Examples of sensitizing EGFR mutation-positive NSCLC include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S7681.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>VONJO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Myelofibrosis (MF), including primary MF, post-polycythemia Vera MF, and Post-Essential Thrombocythemia MF- approve if the patient has intermediate risk or high risk disease and the patient has a platelet count of less than 50 X 10 <sup>9</sup> /L (less than 50,000/mcL)
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>VORICONAZOLE (ORAL)</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	

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<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Aspergillus-Prophy, systemic w/risk neutropenia-Prophy, systemic w/HIV-Prophy/Tx-6 mo, others-3 mo
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	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.
<b>VOSEVI</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
<b>Age Restrictions</b>	18 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
<b>Coverage Duration</b>	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Indications consistent with current AASLD/IDSA guidance
<b>VOTRIENT</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.

<b>Other Criteria</b>	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 synovial 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).
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	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.
<b>VUMERITY</b>	
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
<b>Required Medical Info</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of MS.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>WELIREG</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years

<b>Other Criteria</b>	Van Hippel-Lindau Disease-approve if the patient meets the following (A, B, and C): A) Patient has a von Hippel-Lindau (VHL) germline alteration as detected by genetic testing, B) Does not require immediate surgery and C) Patient requires therapy for ONE of the following conditions (i, ii, iii, or iv): i. Central nervous system hemangioblastomas, OR ii. Pancreatic neuroendocrine tumors, OR iii. Renal cell carcinoma, OR iv. Retinal hemangioblastoma.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### XALKORI

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	ALK status, high level MET amplification status, MET Exon 14 skipping mutation, and ROS1. For soft tissue sarcoma IMT, ALK translocation.
<b>Age Restrictions</b>	Anaplastic large cell lymphoma-patients greater than or equal to 1 year of age and less than 21 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	NSCLC, recurrent or metastatic disease-approve if the patient meets one of the following: must be ALK-positive as detected by an approved test, or have high level MET amplification or have MET Exon 14 skipping mutation or have ROS1 rearrangement as detected by an approved test. Anaplastic Large Cell Lymphoma-approve if the patient has anaplastic lymphoma kinase (ALK)-positive disease AND has received at least one prior systemic treatment. Histiocytic neoplasm-approve if the patient has ALK rearrangement/fusion-positive disease and meets one of the following criteria (i, ii, or iii): (i. Patient has Langerhans cell histiocytosis, OR ii. Patient has Erdheim-Chester disease OR iii. Patient has Rosai-Dorfman disease.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Soft tissue sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK translocation, NSCLC with high level MET amplification or MET Exon 14 skipping mutation, Histiocytic neoplasms.

### XELJANZ

<b>Exclusion Criteria</b>	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].
<b>Required Medical Info</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RA, JIA/JRA/AS-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.

<b>Coverage Duration</b>	PsA/RA/JIA/JRA/AS/UC-6 months initial, All diagnoses-1 year cont.
<b>Other Criteria</b>	RA initial-approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. PsA initial, approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial and the requested medication will be used in combination with methotrexate or another conventional synthetic disease modifying antirheumatic drug (DMARD), unless contraindicated. UC-Approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least ONE tumor necrosis factor inhibitor for ulcerative colitis or was unable to tolerate a 3-month trial. Juvenile Idiopathic Arthritis (JIA) [or Juvenile Rheumatoid Arthritis] (regardless of type of onset) [Note: This includes patients with juvenile spondyloarthritis/active sacroiliac arthritis]-initial-approve Xeljanz immediate release tablets or solution if the patient meets the following: patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. AS-approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. Continuation Therapy - Patient must have responded, as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>XERMELO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, previous therapy, concomitant therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>XOLAIR</b>	
<b>Exclusion Criteria</b>	Concurrent use with an Interleukin (IL) Antagonist Monoclonal Antibody

<b>Required Medical Info</b>	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).
<b>Age Restrictions</b>	Moderate to severe persistent asthma-6 years and older. CIU-12 years and older. Polyps-18 years and older.
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	asthma/CIU-Initial tx 4 months, Polyps-initial-6 months, continued tx 12 months
<b>Other Criteria</b>	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 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

**XOSPATA**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, FLT3-mutation status
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Lymphoid, Myeloid, or Mixed Lineage Neoplasms

**XPOVIO**

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, prior therapies
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	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 of regimens for multiple myeloma 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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Treatment of multiple myeloma in combination with daratumumb or pomalidomide

**XTANDI**

<b>Exclusion Criteria</b>	
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<b>Required Medical Info</b>	Diagnosis for which Xtandi is being used.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### XURIDEN

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, lab results
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a metabolic specialist, geneticist or physician specializing in the condition being treated
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	

### XYREM

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Medication history
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by a sleep specialist physician or a Neurologist
<b>Coverage Duration</b>	12 months.
<b>Other Criteria</b>	For Excessive daytime sleepiness (EDS) in patients with narcolepsy - approve if the patient has tried one CNS stimulant (e.g., methylphenidate, dexamethylphenidate, 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).
<b>Indications</b>	All FDA-approved Indications.

<b>Off-Label Uses</b>	
<b>YONSA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis, concomitant medications
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Metastatic castration-resistant prostate cancer (mCRPC) - approve if the patient will be using Yonsa in combination with methylprednisolone and the patient meets ONE of the following criteria (i or ii): i. The medication is concurrently used with a gonadotropin-releasing hormone (GnRH) analog OR ii. The patient has had a bilateral orchiectomy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ZARXIO</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	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

<b>Other Criteria</b>	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/mm <sup>3</sup> ], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).
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<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
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<b>Off-Label Uses</b>	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).
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<b>ZEJULA</b>	
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<b>Exclusion Criteria</b>	
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<b>Required Medical Info</b>	
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<b>Age Restrictions</b>	18 years and older
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<b>Prescriber Restrictions</b>	
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<b>Coverage Duration</b>	3 years
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<b>Other Criteria</b>	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. Uterine leiomyosarcoma-approve if the patient has BRCA2 mutation and has tried one systemic regimen.
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<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
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<b>Off-Label Uses</b>	Uterine Leiomyosarcoma
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<b>ZELBORAF</b>	
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<b>Exclusion Criteria</b>	
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<b>Required Medical Info</b>	BRAFV600 mutation status required.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Melanoma, patient new to therapy must have BRAFV600 mutation for approval AND have unresectable, advanced or metastatic melanoma. HCL - must have tried at least one other systemic therapy for hairy cell leukemia. Thyroid Cancer-patient has disease that is refractory to radioactive iodine therapy. Erdheim-Chester disease, in patients with the BRAF V600 mutation-approve. Central Nervous System Cancer-approve if the patient has BRAF V600 mutation-positive disease AND medication is being used for one of the following situations (i, ii, or iii): i) adjuvant treatment of pilocytic astrocytoma OR pleomorphic xanthoastrocytoma OR ganglioglioma, OR ii) recurrent disease for one of the following conditions: low-grade glioma OR anaplastic glioma OR glioblastoma, OR iii) melanoma with brain metastases AND the medication will be taken in combination with Cotellic (cobimetinib tablets). Histiocytic Neoplasm-approve if the patient has Langerhans cell histiocytosis and one of the following: multisystem disease OR pulmonary disease OR central nervous system lesions AND the patient has BRAF V600-mutation positive disease.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	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, Central Nervous System Cancer, Histiocytic Neoplasm
<b>ZEPOSIA</b>	
<b>Exclusion Criteria</b>	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
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	UC-18 years and older
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Ulcerative Colitis, initial-approve if the patient has tried Humira (a trial of Simponi SC or infliximab would also count) AND Stelara (a trial of Entyvio or Stelara IV would also count). Cont tx-approve if the patient has been established on Zeposia.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ZIEXTENZO</b>	

<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	Cancer pts receiving chemo-6 mo. PBPC-1 mo
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients undergoing PBPC collection and therapy
<b>ZOLINZA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Cutaneous T-Cell Lymphoma including Mycosis Fungoides/Sezary Syndrome-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	
<b>ZYDELIG</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	

<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Marginal Zone Lymphoma
<b>ZYKADIA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Must have metastatic NSCLC that is anaplastic lymphoma kinase (ALK)-positive as detected by an approved test or ROS1 Rearrangement. IMT - ALK Translocation status.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Soft Tissue Sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK Translocation. Patients with NSCLC with ROS1 Rearrangement-First-line therapy.
<b>ZYTIGA</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Authorization will be for 3 years.

<b>Other Criteria</b>	Prostate Cancer-Metastatic, Castration-Resistant (mCRPC)-Approve if abiraterone is being used in combination with prednisone or dexamethasone and the medication is used concurrently used with a gonadotropin-releasing hormone (GnRH) analog or the medication is concurrently used with Firmagon or the patient has had a bilateral orchiectomy. Prostate cancer-metastatic, castration-sensitive (mCSPC)- approve if the medication is used in combination with prednisone and the medication is concurrently used with a gonadotropin-releasing hormone analog or concurrently used with Firmagon 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, ii or iii): i.abiraterone with prednisone is used in combination with gonadotropin-releasing hormone (GnRH) analog OR ii. Patient has had an orchiectomy OR iii. the medication is used in combination with Firmagon. Prostate cancer-very-high-risk-group-approve if according to the prescriber the patient is in the very-high-risk group, the medication will be used in combination with external beam radiation therapy and the patient meets one of the following criteria (i, ii or iii): i. abiraterone is used in combination with gonadotropin-releasing hormone (GnRH) analog OR ii. Patient has had an orchiectomy OR iii. the medication is used in combination with Firmagon.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Prostate Cancer-Regional Risk Group, Prostate cancer-very-high-risk group

<b>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.</b>	
<b>Drug Name</b>	<b>Route of Administration / Dosage Form</b>
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
AMPHOTERICIN B	INJECTION RECON SOLN
APREPITANT	ORAL CAPSULE
APREPITANT	ORAL CAPSULE,DOSE PACK
ARFORMOTEROL	INHALATION SOLUTION FOR NEBULIZATION

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AZATHIOPRINE	ORAL TABLET 50 MG
BUDESONIDE	INHALATION SUSPENSION FOR NEBULIZATION 0.25 MG/2 ML, 0.5 MG/2 ML, 1 MG/2 ML
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
ENGERIX-B (PF)	INTRAMUSCULAR SYRINGE
ENGERIX-B PEDIATRIC (PF)	INTRAMUSCULAR SYRINGE
ENVARBUS XR	ORAL TABLET EXTENDED RELEASE 24 HR
EVEROLIMUS (IMMUNOSUPPRESSIV E)	ORAL TABLET
FORMOTEROL FUMARATE	INHALATION SOLUTION FOR NEBULIZATION
GENGRAF	ORAL CAPSULE
GENGRAF	ORAL SOLUTION
GRANISETRON HCL	ORAL TABLET



INTRALIPID	INTRAVENOUS EMULSION 20 %
INTRON A	INJECTION RECON SOLN
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
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
PLENAMINE	INTRAVENOUS PARENTERAL SOLUTION
PREHEVBRIO (PF)	INTRAMUSCULAR SUSPENSION
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
XATMEP	ORAL SOLUTION
XGEVA	SUBCUTANEOUS SOLUTION
ZORTRESS	ORAL TABLET 1 MG