Medicare Part D drugs that require prior authorization

PA Criteria

Prior Authorization Group	ACTIMMUNE
Drug Names	ACTIMMUNE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Supporting documentation including prescription history with intravenous antibiotics, complete blood count (CBC) with differential identifying anemia or thrombocytopenia. Documented diagnosis of Chronic Granulomatous Disease (CGD) and continued frequent serious infectious episodes while receiving prophylactic antibiotics, OR Diagnosis of severe, malignant osteopetrosis supported by radiological reports, documentation of previous therapy with intravenous antibiotics, and other relevant clinical findings that were used to diagnosis osteopetrosis and which will be monitored for outcomes such as: anemia, thrombocytopenia, splenomegaly, optic atrophy, chronic osteomyelitis. Continued therapy will be considered based on demonstrated response identified by reduction in serious infections requiring intravenous antibiotics (CGD), reduction in hospitalizations due to serious infections (CGD), increase in hemoglobin and platelet counts (osteopetrosis), no more than 50dB decrease in hearing and no evidence of progressive optic atrophy (osteopetrosis), no evidence of a serious bacterial infection requiring antibiotics (osteopetrosis).
Age Restrictions	-
Prescriber Restrictions	Hematologist. Oncologist. Endocrinologist. Infectious Disease specialist. Orthopedist. Rheumatologist
Coverage Duration	3 months initial approval. Remainder of calendar year for extension of therapy
Other Criteria	Actimmune is not covered for idiopathic pulmonary fibrosis

Prior Authorization Group	ADEMPAS
Drug Names	ADEMPAS
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Coverage will not be provided if any of the following are true: Use in pregnancy, Co-administration of Adempas with a phosphodiesterase inhibitor, including specific PDE-5 inhibitors (i.e. sildenafil, tadalafil, vardenafil), nonspecific PDE inhibitors (i.e. theophylline or dipyridamole), nitrates or nitric oxide donors. Presence of pulmonary veno-occlusive disease
Required Medical Information	If WHO Group I verification of pulmonary hypertension due to idiopathic (IPAH), familial (FPAH), drugs or toxins, connective tissue diseases, HIV infection, congenital heart disease, schistosomiasis, sickle cell disease, or a condition that affects the veins and small blood vessels of the lungs. Right sided catheterization identifying: resting mean pulmonary artery pressure (mPAP) greater than or equal to 25 mmHg, and pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg.. If WHO Group 4, verification of CTEPH diagnosis via ventilation-perfusion scanning and confirmatory pulmonary angiography AND Documentation of persistence/recurrence of CTEPH following surgical treatment OR Documentation that indicates patient is not considered a surgical candidate for the treatment of CTEPH. If WHO Group 1, vasoreactive testing is recommended for all PAH patients (documentation with rationale must be provided for patients for whom this testing is not performed). Documentation of previous and current therapies identifying outcome. Extension of therapy will be dependent upon documentation of clinical response and lack of deterioration
Age Restrictions	18 years old and older
Prescriber Restrictions	Cardiologist or pulmonologist
Coverage Duration	Initial 4 months with 12 month extensions
Other Criteria	For WHO Group 1 (new starts only), documentation is required demonstrating failure or inadequate response to a trial of one of the following: Orally administered PDE-5 inhibitor approved for the treatment of PAH (i.e. tadalafil or sildenafil) or Endothelin receptor antagonist-ambrisentan or Opsumit. Combination therapy with other PAH agents will not be covered for initial therapy. Doses greater than the FDA approved maximum dose will not be covered

Prior Authorization Group	ALPHA1-ANTITRYPSIN REPLACEMENT THERAPY
Drug Names	ARALAST NP, GLASSIA, PROLASTIN-C, ZEMAIRA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Not covered if any of the following situations are true: 1. PiMZ or PiMS phenotypes 2. Members identified with selective IgA deficiencies (IgA level less than 15mg per dl) who have known antibodies against IgA, since they may experience severe reactions 3. Dosing exceeding package labeling 4.Frequency exceeding once weekly infusions 5. Coverage is not provided for doses exceeding package labeling. 6. Emphysema not due to AAT deficiency.
Required Medical Information	Progressive clinically evident emphysema with a documented rate of decline in forced expiratory volume in 1 second (FEV1) post bronchodilation less than 80% predicted except when: 1. Nearly normal pulmonary function if they experience a rapid decline in lung function (FEV1 greater than 120 ml/yr) OR 2. Poor lung function and currently receiving standard treatment. AAT serum level less than 11 micrometer or less than 80mg per dL., rate of decline in forced expiratory volume in 1 second (FEV1) post bronchodilation less than 80% predicted , Phenotype is identified as PiZZ, PiZ(null) or Pi(null)(null). Continued therapy will be considered based on demonstrated response in slowing progression of lung function decline
Age Restrictions	-
Prescriber Restrictions	Must be ordered or followed by a pulmonologist
Coverage Duration	3 months initial approval. Remainder of contract year for extension of therapy.
Other Criteria	-

Prior Authorization Group	AMBRISENTAN
Drug Names	AMBRISENTAN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Coverage will not be provided for: more than 1 tablet per day, or for the treatment of digital ulcers or erectile dysfunction.
Required Medical Information	Verification of WHO Group I pulmonary hypertension due to idiopathic (IPAH), familial (FPAH), drugs or toxins, connective tissue diseases, HIV infection, congenital heart disease, schistosomiasis, sickle cell disease, or a condition that affects the veins and small blood vessels of the lungs. Right sided catheterization identifying: resting mean pulmonary artery pressure (mPAP) greater than or equal to 25 mmHg, and pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg. Vasoreactive testing is recommended for all PAH patients.(Documentation with rationale must be provided for patients that have not been tested). For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.
Age Restrictions	18 years old and older
Prescriber Restrictions	Ordered by or Consult with pulmonologist or cardiologist
Coverage Duration	Initial authorization will be limited to 3 months. Extended authorizations limited to 12 months
Other Criteria	-

Prior Authorization Group	ANTIMETABOLITES
Drug Names	INQOVI, LONSURF, ONUREG
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis for the requested drug, with current clinical documentation of any previous therapies tried.
Age Restrictions	-
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	-

Prior Authorization Group	ARCALYST
Drug Names	ARCALYST
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	The use of Arcalyst will not be considered medically necessary for any of the following: 1. Dosing other than FDA approved dosing regimen. 2. In combination with other interleukin-1 inhibitor. 3.In combination with TNF inhibitor.
Required Medical Information	Skin biopsy if performed. C-reactive protein. Extension of therapy will be medically necessary if documentation identifies symptom improvement or disease stability.
Age Restrictions	-
Prescriber Restrictions	Restricted to a cardiologist, rheumatologist, immunologist or dermatologist
Coverage Duration	Initial 6 month approval followed by an additional 6 months if medically necessary.
Other Criteria	-

Prior Authorization Group	ARMODAFINIL
Drug Names	ARMODAFINIL
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Condition armodafinil is being used to treat. Narcolepsy with Excessive Daytime Sleepiness indication the following is required: Sleep Latency Test results. Obstructive Sleep Apnea indication the following are required: Polysomnography results
Age Restrictions	18 years old and older
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	Narcolepsy with Excessive Daytime Sleepiness-patients must have had a positive Multiple Sleep Latency Test (MSLT). Obstructive Sleep Apnea-patients must have had a positive Polysomnography. For Shift Work Sleep Disorder the patient's symptoms should not be attributable to any co-morbid medical or mental condition. Continuation of therapy will require documentation of improvement in alertness or relevant clinical sign/symptom.

Prior Authorization Group	AURYXIA
Drug Names	AURYXIA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	For the treatment of iron deficiency anemia in adult patients with chronic kidney disease not on dialysis. Prescription medications used as vitamin or mineral products, are excluded from Medicare Part D coverage. Auryxia is considered a vitamin or mineral product when used for the treatment of iron deficiency anemia. For the treatment of hyperphosphatemia in adult patients with chronic kidney disease NOT on dialysis
Required Medical Information	Current clinical documentation indicating the use for Auryxia
Age Restrictions	-
Prescriber Restrictions	Ordered by or Consult with nephrologist
Coverage Duration	12 months
Other Criteria	-

Prior Authorization Group	B VS. D
Drug Names	ABELCET, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ALBUTEROL SULFATE, AMPHOTERICIN B, APREPITANT, ARFORMOTEROL TARTRATE, ASTAGRAF XL, AZATHIOPRINE, BLEOMYCIN SULFATE, BUDESONIDE, CINACALCET HYDROCHLORIDE, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE, CYTARABINE AQUEOUS, ENGERIX-B, ENVARSUS XR, EVEROLIMUS, FLUOROURACIL, FORMOTEROL FUMARATE, GENGRAF, GRANISETRON HYDROCHLORIDE, HEPLISAV-B, INTRALIPID, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, LEVALBUTEROL, LEVALBUTEROL HCL, LEVALBUTEROL HYDROCHLORID, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON HYDROCHLORIDE, ONDANSETRON ODT, PENTAMIDINE ISETHIONATE, PREHEVBRIO, PREMASOL, PROCRIT, PROGRAF, PROSOL, PULMOZYME, RECOMBIVAX HB, SIMULECT, SIROLIMUS, TACROLIMUS, THYMOGLOBULIN, TOBRAMYCIN, TOBRAMYCIN SULFATE, TRAVASOL, TROPHAMINE, VARUBI, YUPELRI
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	NA
Other Criteria	-

Prior Authorization Group	BENLYSTA
Drug Names	BENLYSTA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Benlysta has not been evaluated and is not recommended in patients with severe active central nervous system lupus or in combination with other biologic products.
Required Medical Information	Patient has a diagnosis of active systemic lupus erythematosus (SLE) with one of the following lab results identifying the patient is auto-antibody positive: Antinuclear antibody (ANA) positive greater than or equal to 1:80 OR Anti-double-stranded DNA greater than or equal to 30IU/mL. Documentation that the patient has at least four of the following conditions: malar rash, arthritis, hematologic disorder, discoid rash, serositis, immunologic disorder, photosensitivity, renal disorder, antinuclear antibodies, oral ulcers or neurologic disorder. Must have failure or inadequate response to a 12-week trial of two of the following categories unless contraindicated: corticosteroids, anti-malarials (chloroquine, hydroxychloroquine), or immunosuppressives (methotrexate, azathioprine, cyclophosphamide, mycophenolate) Patient has active lupus nephritis, and Benlysta will be used in combination with standard therapy including, but not limited to, corticosteroids, cyclosporine, tacrolimus, cyclophosphamide, azathioprine, mycophenolate.
Age Restrictions	-
Prescriber Restrictions	Rheumatologist, nephrologist
Coverage Duration	6 months initial, extension 12 months
Other Criteria	Documentation of response to Benlysta must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms of the disease state.

Prior Authorization Group	BIOLOGIC RESPONSE MODIFIERS
Drug Names	AKEEGA, DAURISMO, FARYDAK, IBRANCE, IDHIFA, LYNPARZA, NINLARO, RUBRACA, TALZENNA, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, XPOVIO, XPOVIO 60 MG TWICE WEEKLY, XPOVIO 80 MG TWICE WEEKLY, ZEJULA, ZYDELIG
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis for the requested drug, with current supporting clinical documentation
Age Restrictions	-
Prescriber Restrictions	Oncologist, hematologist
Coverage Duration	12 months
Other Criteria	-

Prior Authorization Group	BRONCHITOL
Drug Names	BRONCHITOL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Must be prescribed for the treatment of add-on maintenance therapy for the diagnosis of cystic fibrosis AND confirmation that the patient is a candidate for mannitol therapy as determined by passing the Bronchitol Tolerance Test (BTT).
Age Restrictions	18 years of age and older
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	Must be prescribed concurrently with a short-acting bronchodilator (such as albuterol, levalbuterol, or ipratropium-albuterol). For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.

Prior Authorization Group	CAYSTON
Drug Names	CAYSTON
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Known allergy to aztreonam
Required Medical Information	Diagnosis of cystic fibrosis and sputum culture positive for Pseudomonas aeruginosa, FEV1 results
Age Restrictions	-
Prescriber Restrictions	Pulmonologist and infectious disease
Coverage Duration	12 months
Other Criteria	Patient must have FEV1 between 25% and 75% of predicted and not be colonized with Burkholderia cepacia

Prior Authorization Group	CGRP ANTAGONISTS
Drug Names	AIMOVIG, AJOVY, EMGALITY
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the preventative treatment of migraines, the requested drug will be covered when the following criteria are met: the patient has experienced an inadequate treatment response, intolerance, or contraindication to, a 4 week trial with ANY of the following preventative drug classes: anti-epileptic drugs, beta-adrenergic blockers, antidepressants, OR the patient has received at least 3 months of treatment with the requested drug, and had a reduction in migraine days per month from baseline. For episodic cluster headache (Emgality only), the request indicates the patient has experienced an inadequate treatment response, or intolerance to, a 4-week trial of one medication class supported in the compendia for preventative treatment, such as verapamil.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial approval 3 months, continuation 12 months.
Other Criteria	For continued therapy: physician attestation must be provided with each extension request indicating a reduction in migraine/headache days per month from baseline, or an improvement in the patient's overall condition.

Prior Authorization Group	CORTICOTROPIN
Drug Names	ACTHAR, CORTROPHIN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Patients with medical contraindications for use identified in package label, including: scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, presence or history of peptic ulcer, congestive heart failure, uncontrolled hypertension, or sensitivity to proteins of porcine origin. Treatment of conditions for which corticotropin is indicated when they are accompanied by primary adrenocortical insufficiency or adrenocortical hyperfunction. For use in children under 2 years of age with congenital infections. Administration of live or live attenuated vaccines in patients receiving immunosuppressive doses of corticotropin
Required Medical Information	Acute exacerbation of relapsing-remitting multiple sclerosis (RRMS): Neurology notes including radiologic reports, supporting the diagnosis RRMS must be provided. Documentation of side effects or failure of high-dose oral (prednisone 500mg) and/or IV corticosteroid therapy. Patient is currently being treated with an immunomodulatory drug (i.e. Betaseron, Avonex, dimethyl fumarate, or Copaxone.) Infantile spasms: Documentation supporting diagnosis of infantile spasms, including onset of age, symptom description, EEG results identifying hypsarrhythmia. Dose, frequency, and number of vials per month being requested. Induction of diuresis or proteinuria remission in nephrotic syndrome: Documentation of proteinuria greater than or equal to 3 grams/24 hours. Documentation of side effects or contraindication to corticosteroid therapy OR Documented failure to achieve complete (less than 300 mg/24 hours) or partial remission (300-3500 mg/24 hours) of proteinuria with high dose corticosteroids (prednisone up to 80mg/day). Rheumatic Disorders: documentation of an acute episode or exacerbation of psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis/juvenile idiopathic arthritis or ankylosing spondylitis. Patient is currently being treated with disease modifying antirheumatic drug (DMARD). Documentation of side effects or failure of high-dose oral and/or IV corticosteroid therapy. Documentation of one of the following diagnoses: systemic lupus erythematosus, systemic dermatomyositis, severe erythema multiforme, Steven-Johnson syndrome, serum sickness, inflammatory ophthalmic disease, symptomatic sarcoidosis. Documentation of prior treatments. Documentation of side effects and/or failure of high-dose oral and/or IV corticosteroid therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	Infantile Spams: must be less than 2 years of age. For continuation of therapy, documentation must be provided identifying anticipated length of therapy and improvement in clinical signs and symptoms

Prior Authorization Group	CYSTARAN
Drug Names	CYSTADROPS, CYSTARAN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of cystinosis with corneal crystal accumulation, Corneal cystine crystal score prior to start of therapy
Age Restrictions	-
Prescriber Restrictions	Ophthalmologist
Coverage Duration	12 months
Other Criteria	For continuation of therapy documentation must be provided identifying either a lack of increase or reduction in the corneal cystine crystal score.

Prior Authorization Group	DIACOMIT
Drug Names	DIACOMIT
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	There is no clinical data to support the use of Diacomit as monotherapy in Dravet syndrome. Diacomit as monotherapy is not covered.
Required Medical Information	Prescriber attests that Diacomit will be used for the treatment of seizures associated with Dravet syndrome, and clobazam is currently, or will be used, in conjunction.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	-

Prior Authorization Group	DIFICID
Drug Names	DIFICID
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Stool sample positive for clostridium difficile toxin.
Age Restrictions	-
Prescriber Restrictions	Restricted to Infectious Disease and gastroenterologist.
Coverage Duration	10 days
Other Criteria	Failure of a 10-14 day course of treatment of oral vancomycin. (Recurrence of c. difficile AFTER treatment with vancomycin does not meet the criteria for failure of vancomycin.)

Prior Authorization Group	DRONABINOL
Drug Names	DRONABINOL
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Hypersensitivity to any cannabinoid
Required Medical Information	Documentation of diagnosis, and documentation of any previous therapies
Age Restrictions	For AIDS-associated loss of appetite, 18 years and older
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	For chemotherapy induced nausea and vomiting associated with cancer chemotherapy or for postoperative nausea and vomiting: member must have failed therapy with the following conventional antiemetic treatments: aprepitant or rolapitant in combination with ondansetron, or dolasetron, or granisetron. For AIDS-associated loss of appetite the member must have failed therapy with a trial of megestrol.

Prior Authorization Group	DUPIXENT
Drug Names	DUPIXENT
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Dosing that exceeds FDA-approved labeling for the indication will not be a covered benefit.
Required Medical Information	For Atopic Dermatitis: documentation indicates moderate-to-severe atopic dermatitis. The patient must have an inadequate response to ONE of the following: topical corticosteroids, topical calcineurin inhibitors (tacrolimus ointment, pimecrolimus cream), Eucrisa. For moderate to severe asthma: documentation indicates the patient has eosinophilic phenotype moderate-to-severe asthma, or oral corticosteroid-dependent moderate to severe asthma, with continued exacerbations despite compliant use of a high-dose inhaled corticosteroid (ICS) and a long-acting beta2-agonist (LABA). For add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRwNP): documentation indicates the disease is inadequately controlled with current therapy, such as nasal steroids.
Age Restrictions	-
Prescriber Restrictions	Must be prescribed by or in consultation with a dermatologist, immunologist, gastroenterologist, pulmonologist, otolaryngologist.
Coverage Duration	Initial approval-6 months, extensions-12 months
Other Criteria	For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms of the disease state.

Prior Authorization Group	EGRIFTA
Drug Names	EGRIFTA SV
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Egrifta is not indicated for cosmetic use or weight loss management. There are no data to support improved compliance with anti-retroviral therapies in HIV-positive patients taking Egrifta.
Required Medical Information	Documentation indicating that Egrifta will be used for the treatment of excess abdominal fat in patients with HIV-associated lipodystrophy.
Age Restrictions	18 to 65 years of age
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	For continued therapy: Documentation of response identifies improvement in the clinical signs and symptoms. Examples include improvement in visceral adipose tissue [VAT], decrease in waist circumference, belly appearance.

Prior Authorization Group	ENBREL
Drug Names	ENBREL, ENBREL MINI, ENBREL SURECLICK
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	A. For moderate to severe active adult RA the following must be met: Failed to respond to 1 or more nonbiologic DMARDs, one of which is a trial of a maximally tolerated dose of methotrexate. If the member has a contraindication or significant intolerance to methotrexate, the member must have failed to respond to a trial of 1 other DMARD at a maximally tolerated dose. B. For moderate to severe JIA as indicated by 4 affected joints with limitation of motion, pain, tenderness or both, or persistent symptoms, the following criteria must be met: Failure to respond to at least a trial of one DMARD. C. For the treatment of moderate to severe psoriatic arthritis as indicated by 3 or more tender joints AND 3 or more swollen joints on 2 separate occasions at least 1 month apart, the following criteria must be met: Must have had an inadequate response to at least 1 NSAID, and Failed to respond to a trial of at least 1 DMARD. D. Enbrel for plaque psoriasis will be considered medically necessary when ALL of the following criteria are met: Moderate to severe chronic plaque psoriasis or involvement of the palms, soles of feet, facial or genital regions. A trial of at least one of the following agents was not effective: MTX, oral retinoids, cyclosporine. E: For AS: failure during a 3 month period of 1 NSAID at maximum tolerated dose and BASDAI greater than or equal to 4 and Failure of a 12 week trial of sulfasalazine at maximum tolerated dose in patients with persistent peripheral arthritis, no trial of DMARDS required for pure axial manifestations.
Age Restrictions	Polyarticular juvenile idiopathic arthritis-ages 2 and older, plaque psoriasis-ages 4 and older. Over 18 years old for all other indications.
Prescriber Restrictions	Restricted to rheumatologists or immunologists for members with arthropathies, dermatologists
Coverage Duration	12 months
Other Criteria	For continued therapy: documentation of response (ie, stable condition) to Enbrel must be provided with each request.

Prior Authorization Group	ENSPRYNG
Drug Names	ENSPRYNG
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Patients with an active Hepatitis B infection, or have active, or latent tuberculosis
Required Medical Information	Request must indicate the patient has neuromyelitis optica spectrum disorder (NMOSD) and are anti-aquaporin-4 (AQP4) antibody positive.
Age Restrictions	-
Prescriber Restrictions	Must be prescribed by, or in consult with, a neurologist or ophthalmologist
Coverage Duration	Initial approval-6 months. Extensions thereafter-12 months
Other Criteria	For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement, or stability in the clinical signs and symptoms of NMOSD.

Prior Authorization Group	EPIDIOLEX
Drug Names	EPIDIOLEX
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Request is for an FDA approved indication, or an indication supported in the CMS recognized compendia
Age Restrictions	-
Prescriber Restrictions	Prescribed by, or in consult with a neurologist
Coverage Duration	12 months
Other Criteria	-

Prior Authorization Group	ESBRIET
Drug Names	ESBRIET, PIRFENIDONE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documented diagnosis of idiopathic pulmonary fibrosis (IPF), HRCT results identifying the presence of a usual interstitial pneumonia (UIP) pattern, Lung biopsy confirming UIP if available, PE findings and liver function tests.
Age Restrictions	18 years and older
Prescriber Restrictions	Ordered by, or by consult with, a pulmonologist.
Coverage Duration	6 months
Other Criteria	For continuation of therapy, the documentation must identify an improvement or maintenance of disease.

Prior Authorization Group	EVRYSDI
Drug Names	EVRYSDI
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Concomitant therapy with other treatments for spinal muscular atrophy (SMA)
Required Medical Information	The patient must be diagnosed with Type 1, 2, or 3 spinal muscular atrophy, evidenced by supporting diagnostic genetic tests confirming 0 copies of SMN1, 2 copies of SMN2, OR genetic testing of 5q SMA for any of the following: homozygous gene deletion, homozygous conversion mutation, or compound heterozygote. The patient must have documentation of SMA-associated signs and symptoms and does not require invasive ventilation or a tracheostomy due to advanced SMA disease.
Age Restrictions	-
Prescriber Restrictions	Must be prescribed by a neurologist or geneticist
Coverage Duration	6 months
Other Criteria	For continued therapy: documentation of clinically significant improvement in spinal muscular atrophy-associated signs and symptoms (such as progression, stabilization, or decreased decline in motor function) compared to baseline. Doses exceeding 5mg per day are not a covered benefit.

Prior Authorization Group	FABRY DISEASE
Drug Names	GALAFOLD
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	For Galafold, uncertain clinical significance of variant status should be determined by a genetics professional. Doses or frequency exceeding FDA approved dosing regimen.
Required Medical Information	Treatment with Galafold will be considered medically necessary when the following criteria are met: a. Diagnosis of Fabry disease b. Patient has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data. For continued coverage: Documentation of positive clinical response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Remainder of the contract year.
Other Criteria	-

Prior Authorization Group	FASENRA
Drug Names	FASENRA, FASENRA PEN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Dosing that exceeds FDA-approved labeling for the indication will not be a covered benefit.
Required Medical Information	As add on maintenance therapy for severe asthma: documentation indicates the patient has eosinophilic phenotype severe asthma, with continued exacerbations, requiring oral systemic corticosteroids, despite the use of a high-dose inhaled corticosteroid (ICS) and a long-acting beta2-agonist (LABA).
Age Restrictions	-
Prescriber Restrictions	Must be prescribed by, or in consultation with, an immunologist or pulmonologist
Coverage Duration	Initial approval-3 months, extensions-12 months
Other Criteria	For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms of the disease state.

Prior Authorization Group	FENTANYL
Drug Names	FENTANYL CITRATE, FENTANYL CITRATE ORAL TRA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Increased strength and/or frequency other than approved dosing are excluded. Treatment of acute or postoperative pain. Combination use of short-acting fentanyl products. Monotherapy.
Required Medical Information	Diagnosis of cancer. Documentation indicates that use is for breakthrough cancer pain. For extension of therapy, documentation must identify 1.continued benefit from therapy, and 2.dosing of long-acting product has been evaluated and is at the maximum tolerated dose.
Age Restrictions	Transmucosal solid dosage form restricted to 16 and older. All other forms restricted to 18 years and older.
Prescriber Restrictions	Restricted to oncologists and pain management specialists
Coverage Duration	Initial 3 months approval followed by 6 month intervals.
Other Criteria	Fentanyl oral transmucosal or buccal solid dosage forms require prior authorization (for all quantities) and will be considered medically necessary when all of the following criteria are met: 1. Failure of a trial of at least 2 different immediate-release (short-acting) opioid drugs at the maximum tolerated dose are ineffective to control breakthrough pain. 2. Already receiving but tolerant to a chronic pain around-the-clock extended release formulation. (Opioid tolerant patients are those who are taking around-the-clock medicine consisting of at least 60mg oral morphine, 30mg oral oxycodone, 8mg of oral hydromorphone, or an equianalgesic dose of another opioid daily for one week or longer.)

Prior Authorization Group	FIRDAPSE
Drug Names	FIRDAPSE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Patients with a history of seizures or seizure disorder.
Required Medical Information	1.Diagnosis of LEMS 2. Documentation of a baseline clinical muscle strength assessment (examples may include but are not limited to, a Quantitative Myasthenia Gravis (QMG) score, triple-timed up-and-go test (3TUG), Timed 25-foot Walk test (T25FW)).
Age Restrictions	6 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Initial coverage: 6 months Continued coverage: 12 months
Other Criteria	Continuation of therapy will be based on a documented positive response evidenced by an updated stable or improved clinical muscle strength assessment. Examples may include but are not limited to, a Quantitative Myasthenia Gravis (QMG) score, triple-timed up-and-go test (3TUG), Timed 25-foot Walk test (T25FW). Non-FDA approved diagnoses will be evaluated according to the CMS medically accepted indications requirements in Chapter 6 of the Medicare Prescription Drug Benefit Manual.

Prior Authorization Group	FORTEO
Drug Names	FORTEO, TERIPARATIDE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of osteoporosis in Postmenopausal female or primary hypogonadal male at high risk of fracture. Glucocorticoid induced osteoporosis on a daily dose equivalent to 5mg or greater of prednisone for at least 3 months and at high risk for fracture. And one of the following: 1. The member has a BMD T-score of less than or equal to -2.5 at the hip, femoral neck or spine and has documented failure of bisphosphonate therapy unless the member has a contraindication or intolerance to bisphosphonates: or 2. The member has a history of at least one osteoporotic/fragility fracture. For continued therapy must demonstrate maintenance in BMD of the lumbar spine, femoral neck, or whole body.
Age Restrictions	18 years old and older
Prescriber Restrictions	-
Coverage Duration	24 months
Other Criteria	Doses exceeding the FDA approved package labeling are not covered. Teriparatide is not a covered benefit in the following situations: prevention of osteoporosis in men and women, members with Paget's disease or unexplained elevations of alkaline phosphatase, members with a history of bone metastases, skeletal malignancies and/or metabolic bone disease other than osteoporosis, members with hypercalcemia, or in combination with a bisphosphonate. The use of teriparatide for more than 2 years during a patient's lifetime should only be considered if a patient remains at, or has returned to having a high risk for fracture.

Prior Authorization Group	GAUCHERS DISEASE
Drug Names	MIGLUSTAT
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	The use of these agents will not be considered medically necessary in the following situations: members with Type 2 or Type 3 Gaucher's Disease. asymptomatic Type 1 disease. carriers of Gaucher's Disease. combination use of any of these agents. Miglustat is not covered for severe disease (severe disease defined as a hemoglobin concentration below 9 g/dL or a platelet count below 50 x 10 to the 9th/L or active bone disease). Miglustat is not covered for diagnosis other than Type 1 Gaucher Disease. Miglustat is not covered if there is no documented allergy, hypersensitivity, or poor venous access to enzyme replacement therapy. These agents are not covered for any diagnosis other than Gaucher's disease.
Required Medical Information	Medical information required for miglustat is as follows: diagnosis of Gaucher's Disease Type 1 confirmed by biochemical assay AND member is experiencing symptomatic manifestations of the disease AND member has a contraindication for use of enzyme replacement therapy such as allergy, hypersensitivity reaction or poor venous access.
Age Restrictions	Miglustat is restricted 18 years and greater.
Prescriber Restrictions	-
Coverage Duration	Remainder of the contract year.
Other Criteria	-

Prior Authorization Group	GLP-1 RECEPTOR AGONISTS
Drug Names	BYDUREON BCISE, BYETTA, MOUNJARO, OZEMPIC, RYBELSUS, TRULICITY
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documented diagnosis of Type 2 Diabetes Mellitus (T2DM) and history or contraindication for the use of at least one other anti-diabetic agent in the past 180 days.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Remainder of contract year
Other Criteria	Will not be covered for the treatment of obesity

Prior Authorization Group	GRASTEK
Drug Names	GRASTEK
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Severe, unstable or uncontrolled asthma. History of eosinophilic esophagitis. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. Will not be covered if receiving subcutaneous allergen immunotherapy
Required Medical Information	Patient has documented allergic rhinitis with or without conjunctivitis. Hypersensitivity to Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard, Perennial Rye, Kentucky Blue Grass, Meadow Fescue, and Redtop) should be confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies prior to administration. Documentation must identify failure of at least TWO of the following treatments: an intranasal corticosteroid, oral antihistamine, or an oral leukotriene receptor antagonist.
Age Restrictions	Ages 5 through 65 years of age
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	Treatment must be initiated at least 12 weeks before expected pollen season based on geographic location (start of season usually late April in Northeast). Therapy should be initiated in January/February in Northeast. For continuation of treatment, the benefits of treatment (decrease of symptoms, increase tolerance to grass pollen) must be documented. Patients that were on active therapy daily for 3 consecutive years must wait at least 1 year until coverage may be reinitiated, unless patients experience a documented severe increase in symptoms compared to the past 3 years.

Prior Authorization Group	GROWTH HORMONE THERAPY
Drug Names	HUMATROPE, NORDITROPIN FLEXPRO
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	GH will not be covered for the following: patient has an active malignant condition, patient is in a non-euthyroid state. If GHD results from an intracranial tumor, absence of tumor growth or tumor recurrence for at least 6 months prior to therapy initiation. GH is not indicated for treatment of wounds or burns. PWS with 1 or more risk factors including severe obesity, h/o respiratory impairment or sleep apnea, or unidentified respiratory infection. Catabolic illnesses or to improve muscle strength or exercise tolerability. Members w/ active proliferative or severe non-proliferative (preproliferative) diabetic retinopathy. Extension of therapy for children for GHD will not be covered if epiphyseal fusion is complete OR bone age indicates growth is complete OR renal transplant has occurred (for CRI) OR growth rate of 2cm/yr has not occurred. IGF-1 in combo with GH is not covered.
Required Medical Information	A.GHD:ht must be beneath 3rd percentile of normal or 2 SD below 50th percentile AND growth velocity must be less than 10th percentile of normal or greater than 2 SD below the mean AND lack of response to 2 separate GH provocative tests. B. Children with Turners Syndrome: present ht must be below the 5th percentile of normal OR ht greater than 2 SD below the mid-parental ht prediction or growth velocity less than 25% for bone age and bone age less than 14 years. C. Children w/ PWS: Severe hypotonia in neonates, followed by hyperphagia and obesity. D. ISS: in the presence of GH deficiency AND with open growth plates AND ht less than the 3rd percentile AND growth velocity less than 10th percentile.
Age Restrictions	Per package label
Prescriber Restrictions	Endocrinologists or Nephrologists
Coverage Duration	12 months
Other Criteria	-

Prior Authorization Group	HEPATITIS C TREATMENT
Drug Names	EPCLUSA, HARVONI, MAVYRET, SOVALDI, VOSEVI, ZEPATIER
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation of chronic hepatitis C infection, HCV RNA level and genotype, Child-Pugh class
Age Restrictions	-
Prescriber Restrictions	Infectious disease physician, Gastroenterologist or Hepatologist
Coverage Duration	12 to 24 weeks based on drug and indication
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance

Prior Authorization Group	HEREDITARY ANGIOEDEMA
Drug Names	CINRYZE, ORLADEYO, RUCONEST
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of hereditary angioedema (HAE) with lab data confirming diagnosis: a.C1-INH and serum complement factor 4 level below the reference range along with a serum C1q level within normal reference range, OR b. C1-INH level that is normal or elevated but dysfunctional, low C4 level and normal C1q level, OR c. Normal C1-INH with normal functional assay and normal C4 and C1q levels.
Age Restrictions	Cinryze-6 years and older, Ruconest-13 years and older, Orladeyo-12 years and older
Prescriber Restrictions	Allergist, immunologist or hematologist
Coverage Duration	6 months initial, extension 12 months
Other Criteria	Ruconest will only be approved for the treatment of acute attacks. Extensions of therapy must identify disease state improvement. For Cinryze or Orladeyo, extensions of therapy must identify disease state improvement (such as a decrease in the number, severity, and/or duration of acute hereditary angioedema attacks)

Prior Authorization Group	HETLIOZ
Drug Names	HETLIOZ, TASIMELTEON
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of non-24-hour sleep-wake disorder, or for the treatment of nighttime sleep disturbances in patients with Smith-Magenis syndrome. Sleep disturbance cannot be explained by other current sleep disorder, medical or neurological disorder, mental disorder, medication use of substance use disorder.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months initial, extension 12 months
Other Criteria	Patient must have history of insomnia, excessive daytime sleepiness or both, which alternate with asymptomatic episodes.

Prior Authorization Group	HUMIRA
Drug Names	HUMIRA, HUMIRA PEDIATRIC CROHNS D, HUMIRA PEN, HUMIRA PEN-CD/UC/HS START, HUMIRA PEN-PEDIATRIC UC S, HUMIRA PEN-PS/UV STARTER
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	A. For Rheumatoid Arthritis: documentation of moderately to severely active rheumatoid arthritis with an inadequate response or intolerance to methotrexate or one other DMARD if methotrexate is contraindicated. A prior trial with methotrexate is not required if documentation of acute, aggressive, very rapidly progressive inflammatory symmetrical arthritis disease is provided. B. For moderately to severely active polyarticular juvenile idiopathic arthritis: documentation of an inadequate response or intolerance to 1 DMARD. C. For Psoriatic Arthritis: documentation of active psoriatic arthritis with an inadequate response or intolerance to methotrexate or other disease-modifying antirheumatic drugs (DMARDs), and 1 NSAID trial. D. For Plaque psoriasis: documentation of moderate to severe chronic plaque psoriasis OR involvement of the palms, soles of feet and scalp. An appropriate trial was not effective or contraindicated with one of the following: MTX, oral retinoids, cyclosporine. E: For Ankylosing Spondylitis: documentation of active ankylosing spondylitis or axial spondylarthritis, with an inadequate response or intolerance to 1 NSAID trial, and failure of a 12 week trial of sulfasalazine at maximum tolerated doses in patients with persistent peripheral arthritis. No trial of DMARDS is required for pure axial manifestations. F. For Chrohn's disease or Ulcerative Colitis: documentation of moderate to severely active disease. Patient must be intolerant to 2 different drug classes (examples such as, but not limited to, corticosteroids and immunomodulators such as azathioprine or mercaptopurine). G. For Hidradenitis Suppurativa (HS): documentation of moderate to severe hidradenitis suppurativa. H. For Uveitis: documentation of non-infectious uveitis (including intermediate, posterior, and panuveitis)
Age Restrictions	-
Prescriber Restrictions	Restricted to rheumatologists or immunologists for members with arthropathies, dermatologists, gastroenterologists, colorectal surgeons, ophthalmologist
Coverage Duration	12 months
Other Criteria	A frequency/dose greater than 40mg every other week is not covered for Crohn's Disease, Ulcerative colitis, Plaque Psoriasis and Uveitis, except for the initial induction period. Continuation of therapy for all indications will require documentation of improvement of clinical signs and symptoms. Concomitant therapy with other biologic or targeted therapies will not be covered.

Prior Authorization Group	ICATIBANT
Drug Names	ICATIBANT ACETATE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation of the following must be provided: 1. Laboratory data confirming diagnosis of hereditary angioedema (HAE) with one of the following: a.C1-INH and serum complement factor 4 level below the reference range along with a serum C1q level within normal reference range, OR b. C1-INH level that is normal or elevated but dysfunctional, low C4 level and normal C1q level, OR c. Normal C1-INH with normal functional assay and normal C4 and C1q levels AND Family history of HAE, if any. 2. Medications that may trigger or worsen angioedema have been evaluated and discontinued if appropriate. (Examples of these are estrogen contraceptives, hormone replacement therapy, and ACE-Inhibitors.) 3. Prescribed for acute attacks (not for prophylaxis) and not for stock for future attacks (i.e. not stockpiling). 4. Member is not currently receiving medications that may trigger or worsen angioedema. For continued use, the following documentation must be identified following icatibant use: diminished symptoms, decreased severity of attack, reduced duration of attacks, and decreased hospitalizations when compared to previous therapies. Please provide date of last attack.
Age Restrictions	-
Prescriber Restrictions	Allergist, immunologist, or hematologist
Coverage Duration	3 month intervals
Other Criteria	Not to be used in combination with Kalbitor or Berinert.

Prior Authorization Group	IMMUNOGLOBULIN THERAPY
Drug Names	BIVIGAM, GAMASTAN, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PANZYGA, PRIVIGEN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Myasthenia gravis w/ acute severe decompensation when 2 standard treatments such as pyridostigmine and steroids failed. HIV infected child with CD4 more than 200u/L. Recurrent severe inf w/ severe def or absence of IgG. Clinically significant functional def of humoral immunity as evidenced by failure to produce antibodies to specific antigens and a h/o of recurrent inf. Solid organ transplant if transplant was for a MVP covered indication and the patient was CMV sero-neg pre transplantation and the donor is sero-positive. ITP in pregnancy if: pregnant who have previously delivered infants w/ autoimmune thrombocytopenia, have PLT counts less than 75,000/mm3 during the current pregnancy. Polymyositis and dermatomyositis: unresponsive or intolerant to steroids and immunosuppressants. IVIG will be used to decrease the doses of other drugs that are needed for treatment. Must show that there was a measurable response w/i 6 months, or its use will no longer be covered. Sensitized renal cell transplant: IVIG and/or plasmapheresis are used in several sequential treatments pre or post-transplant to help w/ pts sensitized to living or cadaveric donors. This attempts to modify PRA level, a cross match result, with prevention and/or treatment of organ rejection) Kawasaki fever within 7 days. Hypogammaglobulinemia and B-cell CLL undergoing allogeneic BMT and at risk for septicemia. Autoimmune mucocutaneous blistering diseases, interstitial pneumonia in post-BMT patients: failure of steroids. Idiopathic infections: 3 hospitalizations w/i past 12 months d/t infections AND low IgG GVHD, CMV: use in BMT patients. Guillain-Barre syndrome, Hemolytic uremic syndrome: failure of plasma exchange. RRMS after failure of methylpred and Copaxone or interferon. Polyradiculoneuropathy: failure of 2 therapies such as steroids and azathioprine or MTX.ITP in pregnancy: IVIG can be used first line with corticosteroids. Humoral or vascular allograft rejection: can be used first line.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial approval 3 months with extension of 6 month intervals.
Other Criteria	IVIG may be covered under Medicare Part B or D depending upon the circumstances. When covered under Part B, IVIG is not covered under Part D. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Group	INREBIC
Drug Names	INREBIC
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Clinical documentation indicating that the patient has intermediate-2, or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis, with a baseline platelet count of 50 X 109 cells/L or greater. A baseline Myeloproliferative Neoplasm Symptom Assessment Form (MPN-SAF) total symptom score is recommended for monitoring symptoms during treatment. Symptoms may include fatigue, night sweats, itching, bone pain, fever, weight loss. For Polycythemia Vera, the patient must also have an inadequate response or intolerance to therapy with hydroxyurea.
Age Restrictions	-
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	12 months
Other Criteria	More than 120 capsules per 30 days are not covered. For continued therapy, the patient must demonstrate a decrease in symptoms evidenced by clinical chart note documentation, or a decrease in the MPN-SAF total symptom score from baseline.

Prior Authorization Group	ITRACONAZOLE
Drug Names	ITRACONAZOLE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Congestive heart failure
Required Medical Information	For onychomycosis: Positive KOH test from a nail scraping or a positive pathogenic fungal culture documenting the presence of hyphae consistent with susceptible dermatophytes (tinea unguium).Member is non-immunocompromised (e.g. negative HIV status, not undergoing chemotherapy, not a transplant recipient).Identify location of onychomycosis (e.g. fingernails and/or toenails). For lung fungal infections, start date of itraconazole and: Fungal cultures identifying one of the following1. Blastomycosis. 2. Histoplasmosis. 3. Aspergillosis.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Onychomycosis-12 weeks, all other indications-12 months
Other Criteria	For onychomycosis infection: failure or contraindication to terbinafine. For aspergillosis fungal infection: failure or contraindication to amphotericin B therapy. For tinea corporis, cruris or pedis: failure or contraindication to one formulary topical antifungal product such as topical ketoconazole or topical clotrimazole. Combination therapy with more than one antifungal agent (terbinafine, itraconazole, ciclopirox) will not be covered

Prior Authorization Group	IWILFIN
Drug Names	IWILFIN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation that Iwilfin will be used to reduce the risk of relapse in patients with high-risk neuroblastoma (HRNB) who have demonstrated at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy .
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial 3 months, continuation 6 months
Other Criteria	For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.

Prior Authorization Group	JAKAFI
Drug Names	JAKAFI
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Chronic myelogenous leukemia, myelodysplastic syndrome, or other myeloid neoplasm.
Required Medical Information	Clinical documentation indicating that the patient has intermediate or high-risk myelofibrosis including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis. A baseline Myeloproliferative Neoplasm Symptom Assessment Form (MPN-SAF) total symptom score is recommended for monitoring symptoms during treatment. Symptoms may include fatigue, night sweats, itching, bone pain, fever, weight loss. For Polycythemia Vera, the patient must have an inadequate response or intolerance to therapy with hydroxyurea. For acute graft-versus-host disease (GVHD), the patient must be unresponsive, or refractory to steroid treatment. For continued therapy, the patient must demonstrate a decrease in symptoms evidenced by clinical chart note documentation, or a decrease in the MPN-SAF total symptom score from baseline.
Age Restrictions	-
Prescriber Restrictions	Oncologist or transplant specialist
Coverage Duration	12 months
Other Criteria	-

Prior Authorization Group	JYNARQUE
Drug Names	JYNARQUE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	History, signs or symptoms of significant liver impairment or injury (not including uncomplicated polycystic liver disease), use in combination with strong CYP3A inhibitors, inability to sense or respond to thirst, uncorrected abnormal blood sodium concentrations, hypovolemia, hypersensitivity to tolvaptan, urinary outflow obstruction, anuria, patients who have progressed to end-stage renal disease.
Required Medical Information	Diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed by ultrasound. Total kidney volume (TKV) classification of 1C or higher. Chart notes identifying symptoms of ADPKD such as hypertension and flank pain. Blood sodium concentrations, ALT, AST, and bilirubin levels prior to starting therapy.
Age Restrictions	18 years and older
Prescriber Restrictions	Ordered by or Consult with nephrologist
Coverage Duration	3 months. Extended authorizations limited to 6 months
Other Criteria	For continuation of therapy, documentation must be provided of continued monitoring of AST, ALT, and bilirubin monthly for 18 months and every 3 months thereafter. Prescribers must enroll in the REMS Access program.

Prior Authorization Group	KALYDECO
Drug Names	KALYDECO
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation of: Diagnosis of cystic fibrosis (CF). Identification that there is one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and or vitro assay data. For continuation of therapy, documentation provided must identify continued benefit supported by one of the following : Improvement in lung function as determined by the mean absolute change from baseline in percent predicted pre-dose FEV1, decrease in pulmonary exacerbations or improvement in CF symptoms including cough, sputum production, and difficulty breathing.
Age Restrictions	-
Prescriber Restrictions	Pulmonologist
Coverage Duration	6 months
Other Criteria	More than 60 tablets per 30 days are not covered.

Prior Authorization Group	KINASE INHIBITORS
Drug Names	AFINITOR DISPERZ, ALECENSA, ALUNBRIG, AUGTYRO, AYVAKIT, BALVERSA, BOSULIF, BRAFTOVI, BRUKINSA, CABOMETYX, CALQUENCE, CAPRELSA, COMETRIQ, COPIKTRA, COTELLIC, EVEROLIMUS, EXKIVITY, FOTIVDA, FRUZAQLA, GAVRETO, GEFITINIB, ICLUSIG, IMATINIB MESYLATE, IMBRUVICA, INLYTA, IRESSA, JAYPIRCA, KOSELUGO, KRAZATI, LENVIMA 10 MG DAILY DOSE, LENVIMA 12MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 4 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE, LORBRENA, LUMAKRAS, LYTGOBI, MEKINIST, MEKTOVI, NERLYNX, NEXAVAR, PEMAZYRE, PIQRAY 200MG DAILY DOSE, PIQRAY 250MG DAILY DOSE, PIQRAY 300MG DAILY DOSE, QINLOCK, RETEVMO, REZUROCK, ROZLYTREK, RYDAPT, SCEMBLIX, SORAFENIB TOSYLATE, SPRYCEL, STIVARGA, SUNITINIB MALATE, TABRECTA, TAGRISSO, TAZVERIK, TEPMETKO, TRUQAP, TRUSELTIQ, TUKYSA, TURALIO, UKONIQ, VANFLYTA, VIJOICE, VITRAKVI, VIZIMPRO, XALKORI, XOSPATA, ZELBORAF, ZYKADIA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis for the requested drug, with current supporting clinical documentation.
Age Restrictions	-
Prescriber Restrictions	Oncologist, transplant specialist, neurologist, or hematologist. For Ayvakit: Allergist, Immunologist.
Coverage Duration	12 months
Other Criteria	-

Prior Authorization Group	KINERET
Drug Names	KINERET
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Dosing that exceeds FDA-approved labeling for the indication will not be a covered benefit.
Required Medical Information	For Rheumatoid Arthritis: documentation of moderately to severely active rheumatoid arthritis with an inadequate response or intolerance to Enbrel and Humira. For the treatment of cryopyrin-associated periodic syndromes (CAPS), specifically Neonatal-Onset Multisystem Inflammatory Disease (NOMID): documentation of the specified disease state, including any supportive laboratory results if available.
Age Restrictions	-
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, immunologist
Coverage Duration	12 months
Other Criteria	For continued therapy: Documentation must be provided with each extension request indicating improvement, or stability, in the clinical signs and symptoms of the disease while on treatment.

Prior Authorization Group	KISQALI
Drug Names	KISQALI, KISQALI FEMARA 200 DOSE, KISQALI FEMARA 400 DOSE, KISQALI FEMARA 600 DOSE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the diagnosis of breast cancer, must have failure or contraindication to at least ONE of the following: palbociclib (Ibrance) OR abemaciclib (Verzenio).
Age Restrictions	-
Prescriber Restrictions	Oncologists
Coverage Duration	12 months
Other Criteria	-

Prior Authorization Group	KORLYM
Drug Names	KORLYM, MIFEPRISTONE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation of the diagnosis of Crushing's syndrome and that patient has failed surgery or is not a candidate for surgery. Current HbA1c level identifying glucose intolerance
Age Restrictions	18 years and older
Prescriber Restrictions	Endocrinologist
Coverage Duration	Initial 3 month approval, extensions 6 months.
Other Criteria	For continuation of therapy there must be a decrease in the HbA1c level from baseline

Prior Authorization Group	LIDOCAINE PATCH
Drug Names	LIDOCAINE, LIDOCAN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Diabetic neuropathy
Exclusion Criteria	Hypersensitivity to local anesthetics of the amide type (like prilocaine or bupivacaine).
Required Medical Information	Documentation of diagnosis of post-herpetic neuralgia or diabetic neuropathy.
Age Restrictions	18 years old and older
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	Documentation must identify diagnosis of the post-herpetic neuralgia or diabetic neuropathy. Continuation of therapy will require documentation of improvement in the clinical signs and symptoms described.

Prior Authorization Group	LIDOCAINE TOPICAL
Drug Names	LIDOCAINE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation of diagnosis for use
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	-

Prior Authorization Group	LITFULO
Drug Names	LITFULO
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Will not be covered for hair growth for cosmetic use
Required Medical Information	For alopecia areata: diagnosis of severe alopecia areata with documentation of more than 50% scalp hair loss (e.g., Severity of Alopecia Tool [SALT] score of 50 or higher) and other forms of alopecia have been ruled out (e.g., androgenetic alopecia, trichotillomania, telogen effluvium, chemotherapy-induced hair loss, tinea capitis).
Age Restrictions	12 years and older
Prescriber Restrictions	-
Coverage Duration	Initial 6 months, Continuation 12 months
Other Criteria	Use in combination with other Janus kinase (JAK) inhibitors, biologic immunomodulators, cyclosporine, or other potent immunosuppressants will not be covered. For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.

Prior Authorization Group	LUPKYNIS
Drug Names	LUPKYNIS
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	The safety and efficacy of Lupkynis has not been established in combination with cyclophosphamide and is not recommended.
Required Medical Information	Patient has active lupus nephritis, and Lupkynis will be used in combination with mycophenolate mofetil and corticosteroids, unless there is a significant intolerance, or contraindication to these medications.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	The safety and efficacy of Lupkynis has not been established beyond 12 months of therapy and will not be covered.

Prior Authorization Group	MEGESTROL
Drug Names	MEGESTROL ACETATE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Current clinical documentation indicating the use for megestrol
Age Restrictions	18 years old and older
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	Non-FDA approved diagnosis will be evaluated according to the CMS medically accepted indications requirements in Chapter 6 of the Medicare Prescription Drug Benefit Manual

Prior Authorization Group	MODAFINIL
Drug Names	MODAFINIL
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Condition modafinil is being used to treat. Narcolepsy with Excessive Daytime Sleepiness indication the following is required: Sleep Latency Test results. Obstructive Sleep Apnea indication the following are required: Polysomnography results
Age Restrictions	17 years old and older
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	Narcolepsy with Excessive Daytime Sleepiness-patients must have had a positive Multiple Sleep Latency Test (MSLT). Obstructive Sleep Apnea-patients must have had a positive Polysomnography. For Shift Work Sleep Disorder the patient's symptoms should not be attributable to any co-morbid medical or mental condition. Continuation of therapy will require documentation of improvement in alertness or relevant clinical sign/symptom. Non-FDA approved diagnosis will be evaluated according to the CMS medically accepted indications requirements in Chapter 6 of the Medicare Prescription Drug Benefit Manual

Prior Authorization Group	MOVEMENT DISORDERS
Drug Names	AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRAT, INGREZZA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation indicating the patient has tardive dyskinesia. Clinical signs and symptoms can include, but are not limited to, loss of muscle control, especially of the face, arms, and legs, resulting in repetitive involuntary movements.
Age Restrictions	-
Prescriber Restrictions	Restricted to neurologists or psychiatrists
Coverage Duration	12 months
Other Criteria	For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.

Prior Authorization Group	MULPLETA
Drug Names	MULPLETA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation that the patient has chronic hepatic disease, date of upcoming procedure, platelet count prior to the procedure
Age Restrictions	-
Prescriber Restrictions	Ordered by or Consult with a Gastroenterologist, Hepatologist, Hematologist, or Surgeon.
Coverage Duration	4 weeks
Other Criteria	-

Prior Authorization Group	MYALEPT
Drug Names	MYALEPT
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Hypersensitivity to metreleptin. General obesity not associated with congenital leptin deficiency
Required Medical Information	Documentation of: Diagnosis (noting generalized/partial, and congenital/acquired), Serum leptin level, Baseline triglyceride level, Baseline HbA1c level, Baseline fasting glucose level, Patient's current weight.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial approval 6 months, extensions 12 months
Other Criteria	To be eligible for approval of Myalept therapy the patient must NOT have any of the following: Partial lipodystrophy, HIV-related lipodystrophy, Nonalcoholic Steatohepatitis (NASH), History of positive anti-metreleptin antibodies, General obesity in absence of generalized lipodystrophy, Diabetes Mellitus in absence of generalized lipodystrophy, Or hypertriglyceridemia in absence of generalized lipodystrophy. AND to be eligible for approval of Myalept therapy the patient MUST have all of the following: Clinical lipodystrophy (i.e. loss/absence of subcutaneous fat, insulin resistance, hypertriglyceridemia), Pharmacologic treatment of hypertriglyceridemia has been maximized or cannot be tolerated, Insulin therapy for the treatment of hyperglycemia has been maximized. For continued therapy: Documentation of response to Myalept must be provided with each request for extension of therapy that identifies improvement in the HbA1c, triglycerides and fasting glucose from baseline.

Prior Authorization Group	NUEDEXTA
Drug Names	NUEDEXTA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Concomitant use with quinidine, quinine or mefloquine. Patients with a history of quinidine, quinine or mefloquine-induced thrombocytopenia, hepatitis, or other hypersensitivity reaction. Hypersensitivity to dextromethorphan. Use with MAOI or within 14 days of stopping an MAOI Prolonged QT interval. Congenital long QT syndrome, history suggestive of torsades de pointes, or heart failure. Complete AV block without implanted pacemaker, or patients at high risk of complete AV block. Concomitant use of drugs that both prolong QT interval and are metabolized by CYP2D6
Required Medical Information	Diagnosis of pseudobulbar affect (PBA) . Chart notes for the previous 3 months identifying the member's frequency of laughing and crying episodes. Center of Neurologic Studies Liability Scale (CNS-LS) score of greater than 13
Age Restrictions	18 years old and older
Prescriber Restrictions	-
Coverage Duration	Initial approval 3 months, extensions 12 months
Other Criteria	Extensions of therapy will be based on improvement in frequency of laughing and crying episodes and CNS-LS score from baseline

Prior Authorization Group	NUPLAZID
Drug Names	NUPLAZID
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation of a diagnosis of Parkinson's disease for at least one year and severity and frequency of hallucinations and/or delusions
Age Restrictions	18 years and older
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	Hallucinations and/or delusions must have started after the diagnosis of Parkinson's disease. Will not be covered for dementia-related psychosis

Prior Authorization Group	ODACTRA
Drug Names	ODACTRA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Severe, unstable or uncontrolled asthma. History of eosinophilic esophagitis. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. Will not be covered if receiving subcutaneous allergen immunotherapy
Required Medical Information	Patient has documented allergic rhinitis with or without conjunctivitis induced by house dust mite (HDM) allergen. Hypersensitivity to house dust mite (HDM) allergen should be confirmed by in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites, or skin testing to licensed house dust mite allergen extracts prior to use. Documentation must identify failure of at least TWO of the following treatments: an intranasal corticosteroid, oral antihistamine, or an oral leukotriene receptor antagonist.
Age Restrictions	Adults 18 through 65 years of age
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	For continuation of treatment, the benefits of treatment (decrease of symptoms, increase tolerance to HDM allergen) must be documented.

Prior Authorization Group	ODOMZO
Drug Names	ODOMZO
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of locally advanced basal cell carcinoma (BCC), having recurred following surgery or radiation therapy or not being a candidate for surgery or radiation therapy.
Age Restrictions	18 years and older
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	Basal cell carcinoma must have recurred following surgery or radiation therapy or the patient is not a candidate for surgery or radiation therapy.

Prior Authorization Group	OFEV
Drug Names	OFEV
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documented diagnosis of idiopathic pulmonary fibrosis (IPF), scleroderma (systemic sclerosis)-associated interstitial lung disease (SSc-ILD), or chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype. High resolution computed tomography (HRCT) results, PE findings and liver function tests if available.
Age Restrictions	-
Prescriber Restrictions	Ordered by, or by consult with, a pulmonologist.
Coverage Duration	6 months
Other Criteria	For continuation of therapy, the documentation must identify an improvement or maintenance of disease.

Prior Authorization Group	OGSIVEO
Drug Names	OGSIVEO
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documented diagnosis of progressing desmoid tumors where systemic treatment is required.
Age Restrictions	-
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	For continued therapy: Documentation that identifies no evidence of disease progression.

Prior Authorization Group	OJJAARA
Drug Names	OJJAARA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Clinical documentation indicating a diagnosis of intermediate or high-risk myelofibrosis (MF), including primary MF or secondary MF (post-polycythemia vera (PV) or post-essential thrombocythemia (ET)) and that the patient has anemia. A baseline total symptom score using the Myelofibrosis Symptom Assessment Form (MFSAF v4.0) is recommended for monitoring symptoms during treatment. Symptoms may include fatigue, night sweats, itching, abdominal discomfort, pain under ribs on left side, feeling of fullness upon eating, bone pain, fever, weight loss.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.

Prior Authorization Group	OPSUMIT
Drug Names	OPSUMIT
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Pregnancy. Coverage will not be provided for the following: treatment of digital ulcers, or dosing exceeding FDA approved package label. Combination therapy with other PAH agents will not be covered for initial therapy.
Required Medical Information	If WHO Group I verification of pulmonary hypertension due to idiopathic (IPAH), familial (FPAH), drugs or toxins, connective tissue diseases, HIV infection, congenital heart disease, schistosomiasis, sickle cell disease, or a condition that affects the veins and small blood vessels of the lungs. Right sided catheterization identifying: resting mean pulmonary artery pressure (mPAP) greater than or equal to 25 mmHg, and pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg.. If WHO Group 4, verification of CTEPH diagnosis via ventilation-perfusion scanning and confirmatory pulmonary angiography AND Documentation of persistence/recurrence of CTEPH following surgical treatment OR Documentation that indicates patient is not considered a surgical candidate for the treatment of CTEPH. If WHO Group 1, vasoreactive testing is recommended for all PAH patients (documentation with rationale must be provided for patients for whom this testing is not performed). Documentation of previous and current therapies identifying outcome. Extension of therapy will be dependent upon documentation of clinical response.
Age Restrictions	18 years old and older
Prescriber Restrictions	cardiologist or pulmonologist
Coverage Duration	Initial authorization will be limited to 3 months. Extension will be for 12 months
Other Criteria	Documentation must include failure or inadequate response to a trial of ambrisentan (for new starts only).

Prior Authorization Group	ORKAMBI
Drug Names	ORKAMBI
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Chart notes identifying diagnosis of cystic fibrosis and test results identifying a homozygous F508del mutation in the CFTR gene. Baseline ppFEV1 results, BMI and number of pulmonary exacerbations in the past 6 months.
Age Restrictions	1 year old and older
Prescriber Restrictions	Pulmonologist
Coverage Duration	6 months
Other Criteria	For extension of therapy member must meet one of the following: 1. stabilization or improvement in ppFEV1 from baseline 2. Increase in BMI from baseline 3. Decrease in the number of pulmonary exacerbations from baseline

Prior Authorization Group	OTEZLA
Drug Names	OTEZLA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Psoriatic Arthritis: documentation of active psoriatic arthritis with an inadequate response or intolerance to methotrexate or other disease-modifying antirheumatic drugs (DMARDs), and 1 NSAID trial. For Plaque Psoriasis: documented diagnosis of plaque psoriasis AND an inadequate response, intolerance or contraindication to one of the following: methotrexate, oral retinoids, cyclosporine. For Behcet's Disease: diagnosis of oral ulcers associated with Behcet's Disease.
Age Restrictions	-
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist, rheumatologist, immunologist
Coverage Duration	12 months
Other Criteria	For continued therapy: Documentation of response to Otezla must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.

Prior Authorization Group	POSACONAZOLE
Drug Names	NOXAFIL, POSACONAZOLE, POSACONAZOLE DR
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation indicates the patient requires posaconazole for one of the following: 1) For the prophylaxis of invasive Aspergillus infections in severely immunocompromised patients who are at high risk of infection. 2) For the prophylaxis of invasive Candida infections in severely immunocompromised patients who are at high risk of infection. 3) For the treatment of oropharyngeal candidiasis, refractory to itraconazole and/or fluconazole. 4) For the treatment of invasive aspergillosis
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months for treatment, 12 months for prophylaxis
Other Criteria	Additional indications for posaconazole (i.e., salvage therapy) will be reviewed based on current references in Medicare approved compendia. Requests for extension will require current clinical chart notes for the documentation of continued medical necessity.

Prior Authorization Group	PRALUENT
Drug Names	PRALUENT
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Request is for an FDA approved indication
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	Patient must have a previous trial, intolerance, or contraindication to a high intensity statin such as atorvastatin 40mg or rosuvastatin 20mg, OR the patient is already established on Praluent therapy.

Prior Authorization Group	PROMACTA
Drug Names	PROMACTA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	PROMACTA will not be covered under Part D if used in an attempt to normalize platelet counts
Required Medical Information	Serum alanine aminotransferase (ALT), aspartate aminotransferase (AST), and bilirubin prior to initiation of PROMACTA, every 2 weeks during the dose adjustment phase and monthly following establishment of a stable dose. Documentation whether member has had a splenectomy. For Diagnosis of chronic immune idiopathic thrombocytopenia purpura and severe aplastic anemia: CBC with differential with Platelet count less than 30 x 10 to the 9th/L. Outcome and length of previous therapies such as IVIG, corticosteroids, cytotoxic therapies, danazol, and azathioprine. For thrombocytopenia in patients with chronic hepatitis C to allow initiation and maintenance of interferon-based therapy: Documentations that the patient is eligible to receive interferon-based therapy. CBC with differential with Platelet count less than 75 x 109/L. Outcomes of any previous therapies such as splenic artery embolization, splenectomy or TIPS.
Age Restrictions	-
Prescriber Restrictions	Gastroenterologist, Hematologist, Infectious Disease Specialist
Coverage Duration	Initial approval will be for 3 months. Extensions of therapy - 12 months
Other Criteria	For the diagnosis of chronic immune idiopathic thrombocytopenia purpura : Degree of thrombocytopenia and clinical condition puts member at an increased risk of bleeding, AND failure or contraindication to the following: 1. IVIG, 2. corticosteroids. For continuation of therapy: a) current platelet count is less than or equal to 200,000/mcL OR b) current platelet count is greater than 200,000/mcL and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding. For the diagnosis of thrombocytopenia in patients with chronic hepatitis C: degree of thrombocytopenia does not allow member to start interferon-based therapy. For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia: may be used in combination with standard immunosuppressive therapy for first-line treatment, or for patients who have had an inadequate response to immunosuppressive therapy. For continuation: a) current platelet count is less than or equal to 200,000/mcL OR b) current platelet count is greater than 200,000/mcL and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding. For all indications, the platelet count must not exceed 400x 10 to the 9th/L after 2 weeks of therapy at lowest FDA approved dose.

Prior Authorization Group	RIBAVIRIN
Drug Names	RIBAVIRIN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Contraindications for the use of ribavirin, including pregnancy, renal failure, hemoglobinopathies.
Required Medical Information	HCV RNA level and genotype
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 to 48 weeks for adults and 24 to 48 weeks for children based on genotype
Other Criteria	Will not be approved as monotherapy for the treatment of hepatitis C. Criteria will be applied consistent with current AASLD/IDSA guidance

Prior Authorization Group	RINVOQ
Drug Names	RINVOQ
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Rheumatoid Arthritis: documentation of moderately to severely active rheumatoid arthritis with an inadequate response or intolerance to methotrexate or one other DMARD if methotrexate is contraindicated. A prior trial with methotrexate is not required if documentation of acute, aggressive, very rapidly progressive inflammatory symmetrical arthritis disease is provided. For Psoriatic Arthritis: documentation of active psoriatic arthritis with an inadequate response or intolerance to Enbrel or Humira. For Atopic Dermatitis: documentation of refractory, moderate to severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when the use of those therapies are inadvisable. For Ulcerative Colitis: documentation of moderately to severely active ulcerative colitis who have had an inadequate response or intolerance to Humira. For Ankylosing Spondylitis: documentation of active ankylosing spondylitis with an inadequate response or intolerance to Enbrel or Humira.
Age Restrictions	-
Prescriber Restrictions	Restricted to rheumatologists, immunologists, dermatologists or gastroenterologists.
Coverage Duration	12 months
Other Criteria	Continuation of therapy will require documentation of improvement in the clinical signs and symptoms of the disease. Concomitant therapy with other biologic or targeted therapies will not be covered.

Prior Authorization Group	SAPROPTERIN
Drug Names	SAPROPTERIN DIHYDROCHLORI
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	The use of sapropterin will not be considered medically necessary for the following situations: Diagnosis other than PKU with Hpa due to BH4-, Doses above 20mg/kg/day. Non-responders (i.e. do not have a decrease in blood Phe with sapropterin treatment after one month of treatment at the maximum dose).Not maintaining Phe levels below baseline. Previous failure of sapropterin.
Required Medical Information	Documentation must be provided for all of the following: Dx of PKU and current mean blood Phe concentration above the upper limit of the recommended ranges which are: Infants less than 1 year of age: 120-360 mol per L. Patients greater than or equal to 2 years of age including pregnant women: 60-360mol per L.. Greater than 12 yo: 2-10mg/dL (120 to 605 micromol per L). If the patient has been using the medication prior to the initial MVP request, the above criteria must have been met prior to initiation and evidence demonstrating a clinically relevant decrease from the baseline mean blood Phe conc after 1 month of sapropterin 20mg/kg/day must be documented in the medical record. Extension of therapy will be considered if documentation supports: mean blood Phe concentration with a clinically significant decrease of blood Phe from mean pretreatment levels continues.
Age Restrictions	-
Prescriber Restrictions	Specialist or prescriber with experience in PKU
Coverage Duration	2 months initial approval, extension 6 months
Other Criteria	-

Prior Authorization Group	SHORT BOWEL SYNDROME
Drug Names	GATTEX
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation indicates the patient is dependent on parenteral nutritional support.
Age Restrictions	-
Prescriber Restrictions	Gastroenterologist
Coverage Duration	Initial approval-3 months, extensions, 6 months.
Other Criteria	For continuation: Requirement for parenteral support has decreased from baseline while on therapy.

Prior Authorization Group	SILDENAFIL
Drug Names	SILDENAFIL CITRATE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Coverage will not be provided for the treatment of digital ulcer or erectile dysfunction. Combination therapy will not be covered for initial therapy.
Required Medical Information	Verification of WHO Group I pulmonary hypertension due to idiopathic (IPAH), familial (FPAH), drugs or toxins, connective tissue diseases, HIV infection, congenital heart disease, schistosomiasis, sickle cell disease, or a condition that affects the veins and small blood vessels of the lungs. Right sided catheterization identifying: resting mean pulmonary artery pressure (mPAP) greater than or equal to 25 mmHg, and pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg. Vasoreactive testing is recommended for all PAH patients.(Documentation with rationale must be provided for patients that have not been tested). Extension of therapy is dependent upon documentation of clinical response. For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.
Age Restrictions	18 years old and older
Prescriber Restrictions	Ordered by or Consult with pulmonologist or cardiologist
Coverage Duration	Initial approval 4 months, extensions 12 months
Other Criteria	-

Prior Authorization Group	SKYRIZI
Drug Names	SKYRIZI, SKYRIZI PEN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Plaque psoriasis: documentation of moderate to severe chronic plaque psoriasis OR involvement of the palms, soles of feet and scalp. An inadequate response or contraindication with one of the following: methotrexate, oral retinoids, cyclosporine. For Psoriatic arthritis: documentation of active psoriatic arthritis with an inadequate response or intolerance to methotrexate or other disease-modifying antirheumatic drugs (DMARDs), and 1 NSAID trial. For Crohn's Disease: documentation of moderate to severely active disease. Patient must have treatement failure, contraindication or intolerance to two different drug classes (examples such as, but not limited to, corticosteroids and immunomodulators such as azathioprine or mercaptopurine).
Age Restrictions	-
Prescriber Restrictions	Restricted to immunologists, dermatologists, gastroenterologists, or rheumatologists.
Coverage Duration	12 months
Other Criteria	Continuation of therapy will require documentation of improvement in the clinical signs and symptoms of the disease. Concomitant therapy with other biologic or targeted therapies will not be covered.

Prior Authorization Group	STELARA
Drug Names	STELARA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Plaque Psoriasis: documentation of moderate to severe chronic plaque psoriasis OR involvement of the palms, soles of feet and scalp, with an inadequate response, intolerance, or contraindication with TWO of the following therapies: Enbrel, Humira, Otezla, Skyrizi. For Psoriatic Arthritis: documentation of active psoriatic arthritis with an inadequate response or intolerance to TWO of the following therapies: Enbrel, Humira, Otezla, Xeljanz/XR. For Crohn's disease: documentation of moderate to severely active disease, with a previous trial, intolerance, or contraindication to Humira. For Ulcerative Colitis: documentation of moderately to severely active ulcerative colitis, with an inadequate response, intolerance, or contraindication to Humira and Xeljanz/XR.
Age Restrictions	-
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist, rheumatologist, or gastroenterologist
Coverage Duration	12 months
Other Criteria	For continued therapy: Documentation of response to Stelara must be provided with each request for extension of therapy that identifies improvement or stability in the clinical signs and symptoms.

Prior Authorization Group	SYMDEKO
Drug Names	SYMDEKO
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation indicates the patient has a diagnosis of cystic fibrosis (CF) that is homozygous for the F508del mutation OR has at least 1 mutation in the CFTR gene that is responsive to tezacaftor, ivacaftor. If the patient's genotype is unknown, an FDA-cleared CF mutation test is recommended. A baseline percent predictive pre-dose FEV1 should be obtained prior to therapy.
Age Restrictions	-
Prescriber Restrictions	Pulmonologist
Coverage Duration	6 months
Other Criteria	More than 60 tablets per 30 days are not covered. For continuation of therapy, documentation provided must identify continued benefit supported by one of the following : Improvement in lung function as determined by the mean absolute change from baseline in the percent predicted pre-dose FEV1, decrease in pulmonary exacerbations or improvement in CF symptoms including cough, sputum production, and difficulty breathing.

Prior Authorization Group	TADALAFIL FOR BPH
Drug Names	TADALAFIL
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Concomitant use of nitrate-based drugs (nitroglycerin) for heart conditions, Hypersensitivity reaction to tadalafil
Required Medical Information	Tadalafil 2.5mg or 5mg will be considered medically necessary when the following criteria are met: Clinical documentation indicates the patient has symptomatic BPH, with failure, or intolerance to a trial of: an alpha-blocker, a 5-alpha-reductase inhibitor, OR the patient has a contraindication to both of these therapies. For continued therapy: clinical documentation indicates a reduction in symptoms.
Age Restrictions	18 years old and older
Prescriber Restrictions	Restricted to urologists (or urology consult identified)
Coverage Duration	Remainder of the contract year.
Other Criteria	Will not be covered solely for: erectile dysfunction (ED) for standard plans, status post radical prostatectomy, in combination with other PDE 5 inhibitors or solely to reduce PSA level. The use of tadalafil 2.5mg tablets will be approved for members with a creatinine clearance of 30 to 50mL/min or in patients that are unable to tolerate the 5mg dose

Prior Authorization Group	TADALAFIL FOR PAH
Drug Names	ALYQ, TADALAFIL
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Concomitant use of organic nitrates or guanylate cyclase stimulators. Will not be covered for the treatment of digital ulcers, erectile dysfunction, or in combination therapy with other phosphodiesterase 5 inhibitors.
Required Medical Information	Verification of WHO Group I pulmonary hypertension due to idiopathic (IPAH), familial (FPAH), drugs or toxins, connective tissue diseases, HIV infection, congenital heart disease, schistosomiasis, sickle cell disease, or a condition that affects the veins and small blood vessels of the lungs. Right sided catheterization identifying: resting mean pulmonary artery pressure (mPAP) greater than or equal to 25 mmHg, and pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg. Vasoreactive testing is recommended for all PAH patients.(Documentation with rationale must be provided for patients that have not been tested). For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.
Age Restrictions	18 years and older
Prescriber Restrictions	Ordered by or consult with pulmonologist or cardiologist
Coverage Duration	Initial 4 months with 12 month extensions
Other Criteria	-

Prior Authorization Group	TAKHZYRO
Drug Names	TAKHZYRO
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation of the following must be provided: 1. Laboratory data confirming diagnosis of hereditary angioedema (HAE) with on of the following: a.C1-INH and serum complement factor 4 level below the reference range along with a serum C1q level within normal reference range, OR b. C1-INH level that is normal or elevated but dysfunctional, low C4 level and normal C1q level, OR c. Normal C1-INH with normal functional assay and normal C4 and C1q levels AND Family history of HAE, if any. 2. Medications that may trigger or worsen angioedema have been evaluated and discontinued if appropriate. (Examples of these are estrogen contraceptives, hormone replacement therapy, and ACE-Inhibitors.) 3. Member is not currently receiving medications that may trigger or worsen angioedema. 4. Member has a history of at 1 acute HAE attack per month. For continued use, the following documentation must be identified following Takhzyro use: diminished symptoms, decreased severity of attacks, reduced duration of attacks, and decreased hospitalizations when compared to previous therapies. Please provide date of last attack.
Age Restrictions	2 years and older
Prescriber Restrictions	Allergist, immunologist, or hematologist
Coverage Duration	3 months. Extended authorizations limited to 6 months
Other Criteria	Not to be used in combination with Cinryze, or Haegarda.

Prior Authorization Group	TALTZ
Drug Names	TALTZ
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Ankylosing Spondylitis: documentation of active ankylosing spondylitis, or active, non-radiographic axial spondyloarthritis with objective signs of inflammation, with an inadequate response, intolerance, or contraindication to ONE the following therapies: Enbrel or Humira. For Psoriatic Arthritis: documentation of active psoriatic arthritis with an inadequate response, intolerance, or contraindication to ONE of the following therapies: Enbrel, Humira, Otezla, Xeljanz/XR. For Plaque Psoriasis: documentation of moderate to severe chronic plaque psoriasis OR involvement of the palms, soles of feet and scalp, with an inadequate response, intolerance, or contraindication to ONE the following therapies: Enbrel, Humira, Otezla, Skyrizi.
Age Restrictions	-
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or rheumatologist
Coverage Duration	12 months
Other Criteria	For continued therapy: Documentation of response to Taltz must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.

Prior Authorization Group	TARGRETIN
Drug Names	BEXAROTENE, TARGRETIN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Clinical chart notes that indicate the patient requires Targretin gel for the treatment of cutaneous lesions of stage IA or IB cutaneous T-cell lymphoma, that have refractory or persistent disease after other therapies, or have not tolerated other therapies. Non-FDA approved diagnoses will be evaluated according to the CMS medically accepted indications requirements in Chapter 6 of the Medicare Prescription Drug Benefit Manual.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Remainder of the contract year
Other Criteria	For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.

Prior Authorization Group	TECVAYLI
Drug Names	TECVAYLI
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of multiple myeloma with documented failure of at least 4 prior lines of therapy including an anti-CD38 monoclonal antibody, a proteasome inhibitor, and an immunomodulatory agent.
Age Restrictions	-
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.

Prior Authorization Group	TEGSEDI
Drug Names	TEGSEDI
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation of the following must be provided: 1. Patient has documented transthyretin (TTR) mutation as confirmed through genetic testing AND Presence of polyneuropathy characterized by ONE of the following: i. Baseline polyneuropathy disability (PND) score less than IIIb ii. Baseline FAP (familial amyloid polyneuropathy) Stage 1 or 2. 2. Patient has a platelet count greater than 100 x 109/L
Age Restrictions	18 years and older
Prescriber Restrictions	Neurologist, immunologist, or physician who specializes in the treatment of amyloidosis
Coverage Duration	3 months. Extended authorizations limited to 6 months
Other Criteria	For continuation of therapy, clinical documentation showing the patient has experienced a positive clinical response to Tegsedi (ie, improved neurologic impairment, motor function, cardiac function, quality of life assessment) must be identified.

Prior Authorization Group	TETRABENAZINE
Drug Names	TETRABENAZINE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Concomitant use with reserpine or use of reserpine within the past 20 days. Members with liver disease. Uncontrolled or untreated depression.
Required Medical Information	Chart notes including: baseline and any subsequent total Chorea Score or the Unified Huntington's Disease Rating Scale (UHDRS), neurological exam, genetic testing confirming Huntington's disease. Documentation of functional disability due to chorea symptoms from Huntington's disease. For continued therapy: Documentation of response must be provided with each request.
Age Restrictions	18 years old and older
Prescriber Restrictions	Restricted to neurologists
Coverage Duration	Initial approval for 3 months. Continuation of therapy six months.
Other Criteria	For doses above 50mg per day testing must be provided identifying patient is an extensive or intermediate metabolizer of CYP2D6.

Prior Authorization Group	TOBI PODHALER
Drug Names	TOBI PODHALER
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Hypersensitivity to any aminoglycoside, Forced expiratory volume in 1 second less than 25% or greater than 80% of predicted normal range, Colonization with Burkholderia cepacia
Required Medical Information	Diagnosis of cystic fibrosis, Positive sputum culture for Pseudomonas aeruginosa, Base line FEV1%. For continuation of therapy the following criteria must be met: Improvement in FEV1% from baseline
Age Restrictions	6 years old and older
Prescriber Restrictions	Pulmonologist and Infectious disease
Coverage Duration	12 months
Other Criteria	Frequency greater than twice daily for 28 days followed by a 28 day drug free period will not be covered

Prior Authorization Group	TOLVAPTAN
Drug Names	TOLVAPTAN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Need to raise serum sodium acutely. Patients who are unable to respond appropriately to thirst. Hypovolemic hyponatremia. Concomitant use of strong CYP 3A inhibitors. Anuric patients. Patients with liver disease.
Required Medical Information	Documentation that the patient has clinically significant hypervolemic and euvolemic hyponatremia (serum sodium less than 125 mEq/L or hyponatremia that is symptomatic and has resisted correction with fluid restriction), including patients with heart failure and syndrome of inappropriate antidiuretic hormone (SIADH). Tolvaptan must be initiated in a hospital setting.
Age Restrictions	18 years old and older
Prescriber Restrictions	Endocrinologists, Nephrologists
Coverage Duration	Maximum of 30 days
Other Criteria	Patients with symptoms that may indicate liver injury should discontinue treatment with tolvaptan. Tolvaptan should not be used longer than 30 days.

Prior Authorization Group	TRETINOINS
Drug Names	AVITA, TRETINOIN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Cosmetic use including wrinkles.
Required Medical Information	The use of topical tretinoins will be considered medically necessary if all of the following criteria are met: Diagnosis of acne vulgaris. Subsequent requests will be considered if there is documentation of: Improvement in acne lesions.
Age Restrictions	10 years old and older
Prescriber Restrictions	-
Coverage Duration	Remainder of contract year
Other Criteria	Failure of a one month trial of each of the following: combination formulary agent containing topical erythromycin and benzoyl peroxide. Combination formulary agent containing topical clindamycin and benzoyl peroxide.

Prior Authorization Group	TRIENTINE
Drug Names	TRIENTINE HYDROCHLORIDE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation of the diagnosis of Wilson's disease, baseline free serum copper level and 24-hour copper excretion results.
Age Restrictions	6 years and older
Prescriber Restrictions	-
Coverage Duration	Initial 6 month approval, extensions 12 months.
Other Criteria	Must have failed therapy with or have a contraindication to the use of Depen. For continuation of therapy there must be a decrease in free serum cooper level and 24-hour copper excretion results from baseline.

Prior Authorization Group	TRIKAFTA
Drug Names	TRIKAFTA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation indicates the patient has a diagnosis of cystic fibrosis (CF) with at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene. If the patient's genotype is unknown, an FDA- cleared CF mutation test is recommended. A baseline percent predictive pre-dose FEV1 should be obtained prior to therapy.
Age Restrictions	-
Prescriber Restrictions	Pulmonologist
Coverage Duration	6 months
Other Criteria	More than 84 tablets per 28 days are not covered. For continuation of therapy, documentation provided must identify continued benefit supported by one of the following : Improvement in lung function as determined by the mean absolute change from baseline in the percent predicted pre-dose FEV1, decrease in pulmonary exacerbations or improvement in CF symptoms including cough, sputum production, and difficulty breathing.

Prior Authorization Group	TYVASO
Drug Names	TYVASO DPI MAINTENANCE KI, TYVASO DPI TITRATION KIT
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation of WHO Group 1 pulmonary hypertension (PAH) or PAH associated with interstitial lung disease (WHO Group 3). Right-sided catheterization identifying: resting mean pulmonary artery pressure (mPAP) greater than or equal to 25 mmHg, and pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg. Vasoreactive testing is recommended for all PAH patients. (Documentation with rationale must be provided for patients that have not been tested).
Age Restrictions	-
Prescriber Restrictions	Ordered by or in consult with a pulmonologist, cardiologist or rheumatologist.
Coverage Duration	Initial approval 6 months, continued approval 12 months
Other Criteria	For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.

Prior Authorization Group	UPTRAVI
Drug Names	UPTRAVI
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Verification of WHO Group I pulmonary hypertension due to idiopathic (IPAH), familial (FPAH), drugs or toxins, connective tissue diseases, HIV infection, congenital heart disease, schistosomiasis, sickle cell disease, or a condition that affects the veins and small blood vessels of the lungs. Right sided catheterization identifying: resting mean pulmonary artery pressure (mPAP) greater than or equal to 25 mmHg, and pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg. Vasoreactive testing is recommended for all PAH patients.(Documentation with rationale must be provided for patients that have not been tested). For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.
Age Restrictions	18 years old and older
Prescriber Restrictions	Pulmonologist or Cardiologist
Coverage Duration	12 months
Other Criteria	Combination therapy with other PAH agents will not be covered for initial therapy

Prior Authorization Group	VALCHLOR
Drug Names	VALCHLOR
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation including workup and skin biopsy results identifying Stage 1A or 1B mycosis fungoides-type cutaneous T-cell lymphoma. Lymph node biopsy if definitive diagnosis cannot be made from skin biopsy. Previous skin-direct therapies
Age Restrictions	18 years old and older
Prescriber Restrictions	Oncologists and Dermatologists
Coverage Duration	Initial 3 month approval, followed by extensions up to 12 months
Other Criteria	Documentation must identify previous treatment with one topical treatment supported by the NCCN Guidelines: Topical corticosteroids, Phototherapy, Topical retinoids, Topical nitrogen mustard or carmustine, Topical imiquimod

Prior Authorization Group	VENTAVIS
Drug Names	VENTAVIS
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Verification of WHO Group I pulmonary hypertension due to idiopathic (IPAH), familial (FPAH), drugs or toxins, connective tissue diseases, HIV infection, congenital heart disease, schistosomiasis, sickle cell disease, or a condition that affects the veins and small blood vessels of the lungs. Right sided catheterization identifying: resting mean pulmonary artery pressure (mPAP) greater than or equal to 25 mmHg, and pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg. Vasoreactive testing is recommended for all PAH patients.(Documentation with rationale must be provided for patients that have not been tested). For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.
Age Restrictions	18 years old and older
Prescriber Restrictions	Ordered by or Consult with pulmonologist or cardiologist
Coverage Duration	Remainder of contract year
Other Criteria	Combination therapy with other PAH agents will not be covered for initial therapy. Ventavis may be covered under Medicare Part B or D depending upon the circumstances. When covered under Part B, Ventavis is not covered under Part D. Information may need to be submitted describing the use and setting of the drug to make the determination. Coverage will be considered if all of the following criteria are met: NYHA Class III or IV primary pulmonary hypertension or pulmonary hypertension secondary to any of the following conditions: Congenital systemic to vascular shunts, Collagen vascular disease, Portal hypertension, HIV infection, drugs/toxins.

Prior Authorization Group	VONJO
Drug Names	VONJO
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Clinical documentation indicating that the patient has intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF), with a platelet count below 50 X 109 cells/L. A baseline Myeloproliferative Neoplasm Symptom Assessment Form (MPN-SAF) total symptom score is recommended for monitoring symptoms during treatment. Symptoms may include fatigue, night sweats, itching, bone pain, fever, weight loss.
Age Restrictions	-
Prescriber Restrictions	Hematologist or Oncologist
Coverage Duration	12 months
Other Criteria	More than 120 capsules per 30 days are not covered. For continued therapy, the patient must demonstrate an increase in platelet count, or a decrease in symptoms evidenced by clinical chart note documentation or a decrease in the MPN-SAF total symptom score from baseline.

Prior Authorization Group	VORICONAZOLE
Drug Names	VORICONAZOLE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Request is for an FDA approved indication, or an indication supported in the CMS recognized compendia
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	VOWST
Drug Names	VOWST
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Will not be covered for the treatment of active Clostridium difficile infection
Required Medical Information	Documentation that Vowst is being used to prevent recurrent Clostridium difficile (CDI) infection. Chart notes documenting previous antibacterial therapy to treat Clostridium difficile infection (such as oral vancomycin, fidaxomicin, etc.) has been completed.
Age Restrictions	18 years and older
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	More than 12 capsules per 30 days will not be covered

Prior Authorization Group	VYNDAMAX
Drug Names	VYNDAMAX
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation indicating the patient has wild type or hereditary transthyretin amyloid cardiomyopathy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Neurologist, cardiologist, or physician who specializes in the treatment of amyloidosis
Coverage Duration	3 months. Extended authorizations limited to 6 months
Other Criteria	For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.

Prior Authorization Group	WAKIX
Drug Names	WAKIX
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation indicates the patient has narcolepsy with Excessive Daytime Sleepiness (EDS) or cataplexy. For excessive daytime sleepiness, the patient must have an intolerance, contraindication, or failure to a one-month trial of the following at the maximum tolerated dose: modafinil OR armodafinil AND a formulary methylphenidate product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial approval: 3 months. Continued therapy: 12 months
Other Criteria	For continued therapy: Request for extension indicates an improvement in symptoms. More than 60 tablets per 30 days are not covered.

Prior Authorization Group	XELJANZ
Drug Names	XELJANZ, XELJANZ XR
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Rheumatoid Arthritis: documentation of moderately to severely active rheumatoid arthritis with an inadequate response or intolerance to methotrexate or one other DMARD if methotrexate is contraindicated. For Psoriatic Arthritis: documentation of active psoriatic arthritis with an inadequate response or intolerance to methotrexate or other disease-modifying antirheumatic drugs (DMARDs), and 1 NSAID trial. For Ulcerative Colitis: documentation of moderately to severely active ulcerative colitis. Patient must be intolerant to 2 different drug classes (examples such as, but not limited to, corticosteroids and immunomodulators such as azathioprine or mercaptopurine). For Ankylosing spondylitis: documentation of active ankylosing spondylitis with an inadequate response or intolerance to Enbrel or Humira. For Polyarticular juvenile idiopathic arthritis: documentation of polyarticular juvenile idiopathic arthritis with an inadequate response or intolerance to Humira.
Age Restrictions	-
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, immunologist, or gastroenterologist
Coverage Duration	12 months
Other Criteria	The use of Xeljanz or Xeljanz XR in combination with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine is not recommended. For continued therapy: Documentation of response to Xeljanz must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.

Prior Authorization Group	XERMELO
Drug Names	XERMELO
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of carcinoid syndrome diarrhea in combination with somatostatin analog (SSA) therapy in patients inadequately controlled by SSA therapy
Age Restrictions	-
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or gastroenterologist
Coverage Duration	12 months
Other Criteria	For continued therapy: documentation of response must be provided with each request for extension of therapy that identifies improvement or stability in the clinical signs and symptoms. Treatment exceeding 250mg three times daily is not a covered benefit.

Prior Authorization Group	XGEVA
Drug Names	XGEVA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documentation indicates the patient requires Xgeva (denosumab) for one of the following indications:1) For the prevention of skeletal-related events in patients with multiple myeloma and in patients with bone metastases from solid tumors. 2) For the treatment of adults and skeletally mature adolescents with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity, 3) For the treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.

Prior Authorization Group	XIFAXAN
Drug Names	XIFAXAN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Will not be covered for prophylactic use or diverticular disease.
Required Medical Information	For diagnosis of active non-invasive travelers diarrhea (TD): Moderate to severe distressing symptoms of travelers diarrhea are present and proven or strongly suspected to be caused by Escherichia coli based upon symptoms and travel destination. (When culture and susceptibility information are available, culture must identify E. coli and susceptible to rifaximin). For diagnosis of hepatic encephalopathy (HE) and Irritable Bowel Syndrome with Diarrhea (IBS-D): current and previous therapies tried.
Age Restrictions	12 years old and older
Prescriber Restrictions	-
Coverage Duration	TD=3 days, HE=6 months, all other indications=6 months
Other Criteria	The 200mg tablets will only be approved for the treatment of travelers diarrhea at a quantity of 9 tablets. For hepatic encephalopathy must be receiving maximum tolerated dose of lactulose and still having breakthrough overt episodes of hepatic encephalopathy. For Irritable Bowel Syndrome with Diarrhea: must have failed therapy with or have a contraindication to the use of loperamide.

Prior Authorization Group	XOLAIR
Drug Names	XOLAIR
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For asthma: documented evidence of reversible airway disease, IgE level, test results identifying allergic sensitivity to perennial aeroallergens, previous and current therapy. For Chronic idiopathic urticaria (CIU): Duration of urticaria, previous and current therapy. For add-on maintenance treatment of chronic rhinosinusitis with nasal polyps: documentation indicates the disease is inadequately controlled with nasal steroids. For IgE-mediated Food Allergies: chart notes documenting confirmed diagnosis of one or more IgE-mediated food allergies.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial approval-3 months, extensions-12 months
Other Criteria	For asthma: member experiencing poor asthma control despite the use of the maximally tolerated dose of a medium to high dose inhaled corticosteroid in combination with a long-acting beta2 agonist or leukotriene inhibitor or theophylline unless contraindicated, IgE level must be between 30 and 1300 IU/ml. For CIU: Urticaria must be present for at least 6 weeks and other causes such as occupational, food, medication, etc. must have been ruled out, must have failed a minimum of a 2 week trial of the maximally tolerated dose of a potent H1 antihistamine in combination with a H2 antihistamine, a systemic corticosteroid or leukotriene receptor antagonist unless contraindicated For continuation of therapy: clinical documentation showing a positive clinical response must be identified.

Prior Authorization Group	XYREM
Drug Names	SODIUM OXYBATE, XYREM
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The use of sodium oxybate will be considered medically necessary when the medical information provided documents the following: Definitive diagnosis of narcolepsy based upon objective sleep studies, AND Quantitatively documented symptoms of excessive daytime sleepiness and/or cataplexy, AND no history of GHB abuse, AND no concomitant use with sedative hypnotics (including anxiolytics) or CNS depressants and daily dose does not exceed 9 grams. Continued therapy will be considered based on demonstrated response of decreasing cataplexy events and improvement in score for appropriate test (e.g. Epworth Sleepiness Scale, Clinical Global Impression of Change, etc.) for EDS.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial approval: 3 months. Continued therapy: 6 months
Other Criteria	Documented intolerance, contraindication, or failure of a 1 month trial of the following at the maximum tolerated dose: For excessive daytime sleepiness (EDS), modafinil or armodafinil, AND a formulary methylphenidate product.

Prior Authorization Group	ZTALMY
Drug Names	ZTALMY
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Cyclin-dependant kinase-like 5 (CDKL5) deficiency disorder (CDD): diagnosis confirmed by genetic testing.
Age Restrictions	-
Prescriber Restrictions	Neurologists
Coverage Duration	Initial approval 6 months, continued approval 12 months
Other Criteria	For continued therapy: Documentation of response must be provided with each request for extension of therapy that identifies improvement in the clinical signs and symptoms.