2019 INJECTABLE DRUG PRIOR AUTHORIZATION CRITERIA

UCare Medicare Classic (HMO-POS)
UCare Value (HMO-POS)
UCare Essentials Rx (HMO-POS)
UCare Standard (HMO-POS)
UCare Prime (HMO POS)
Care Core with Fairview & North Memorial (HMO-POS)
Care Advantage with Fairview & North Memorial (HMO-POS)
EssentiaCare Secure (PPO)
EssentiaCare Grand (PPO)

These drugs require authorization before dispensing and administering. Please reference the Injectable Drug Authorization Guide to determine if authorization will need be obtained through the member’s Part D or Part B benefit.

The prior authorization criteria contained in this document may not apply to UCare Medicare products if Medicare requires different coverage criteria. If Medicare requires different coverage criteria, the applicable NCD or LCD will apply.

Updated: 05/2019
# Actemra

## Products Affected
- ACTEMRA INTRAVENOUS

## PA Criteria

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted indications not otherwise excluded plus patients already started on tocilizumab for a covered use. Castleman's disease. Still's disease.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concurrent use with a biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz, Otezla).</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, previous medication use</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Rheumatoid arthritis (RA), patients 18 years of age and older. Polyarticular Juvenile Idiopathic Arthritis (PJIA) and Systemic Juvenile Idiopathic Arthritis (SJIA), patients 2 years of age and older. All other conditions, 18 years of age and older. Cytokine release syndrome (CRS), patients 2 years of age and older.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>For Castleman's disease must be prescribed by or in consultation with an oncologist or hematologist. For RA, PJIA, SJIA, and Still's Disease, must be prescribed by or in consultation with a rheumatologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For RA, the patient must have a trial with etanercept or adalimumab for at least 3 months unless the patient experienced intolerance. For Still's Disease must have tried a corticosteroid and one conventional DMARD, such as methotrexate, given for at least 2 months or was intolerant to a conventional DMARD. For SJIA (IV only), must have tried one other systemic agent (e.g., a corticosteroid [oral, IV] or a conventional DMARD [e.g., MTX, leflunomide, sulfasalazine] or a biologic DMARD or a 1-month trial of a nonsteroidal anti-inflammatory drug [NSAID]. For PJIA (IV only) must have tried one other systemic agent (e.g., a corticosteroid [oral, IV] or a conventional DMARD [e.g., MTX, leflunomide, sulfasalazine] or a biologic DMARD or a 1-month trial of a nonsteroidal anti-inflammatory drug [NSAID]. For continuation of therapy for all conditions, prescriber attests the patient has had a response to treatment.</td>
</tr>
</tbody>
</table>
## Acthar

### Products Affected
- ACTHAR H.P.

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All medically-accepted indications not otherwise excluded.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Coverage is not provided for diagnostic procedure.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>MS exacerbation, history of corticosteroid use.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Infantile spasms- less than 2 yr. Acute MS exac-adult</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Infantile spasms, prescribed by or in consultation with a neurologist or an epileptologist. MS exacerbation, prescribed by or in consultation with a neurologist or physician that specializes in the treatment of MS.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Infantile spasms, 1 month. MS exacerbation, approve 1 month.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For acute MS exacerbation, approve if the patient cannot use high-dose IV corticosteroids because IV access is not possible or if the patient has tried high-dose corticosteroids administered IV for an acute MS exacerbation and has experienced a severe or limiting adverse effect.</td>
</tr>
</tbody>
</table>
Aliqopa

**Products Affected**
- ALIQOPA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All medically accepted indications not otherwise excluded.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis, Documentation of prior therapies.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Patients 18 years of age or older.</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>1 year for initial treatment, 3 years for continuation.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For follicular lymphoma, must have tried and failed two systemic therapies. Continuation Therapy - prescriber attests the patient has had a response to treatment.</td>
</tr>
</tbody>
</table>
# Azedra

## Products Affected
- AZEDRA DOSIMETRIC
- AZEDRA THERAPEUTIC

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted and FDA-approved indications not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Patients 12 years of age and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by, or in consultation with, an oncologist or radiologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>The patient has iobenguane scan positive, unresectable, locally advanced or metastatic pheochromocytoma OR iobenguane scan positive, unresectable, locally advanced or metastatic paraganglioma. Continuation Therapy - Patient must have responded, as determined by the prescriber.</td>
</tr>
</tbody>
</table>
## Benlysta

### Products Affected
- **BENLYSTA**

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Concurrent Use with Other Biologics (e.g., Rituxan® [rituximab injection]) or with Cyclophosphamide Intravenous (IV)</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>The patient is an adult 18 years of age or older</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>The agent is prescribed by or in consultation with rheumatologist, clinical immunologist, nephrologist, neurologist, or dermatologist</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Authorization will be for 1 year</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>The patient has autoantibody-positive SLE (i.e., positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA] AND The agent is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician. Cont The patient has responded to Benlysta subcutaneous or intravenous (e.g., reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer, improvement in complement levels [i.e., C3, C4], or improvement in specific organ dysfunction [e.g., musculoskeletal, blood, hematologic, vascular, others]), as determined by the prescriber</td>
</tr>
</tbody>
</table>
**Besponsa**

**Products Affected**
- BESPONSA

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<tr>
<th>PA Criteria</th>
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<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted indications not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>For patients 18 years of age or older.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>1 year for initial treatment, 3 years for continuation.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Continuation Therapy - prescriber attests the patient has had a response to treatment.</td>
</tr>
</tbody>
</table>
Brineura

Products Affected
• BRINEURA

<table>
<thead>
<tr>
<th>PA Criteria</th>
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<tbody>
<tr>
<td>Covered Uses</td>
<td>All medically accepted indications not otherwise excluded.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Patient 3 years of age or older.</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a neurologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>1 year for initial treatment, 3 years for continuation.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Continuation Therapy - prescriber attests the patient has shown a response to treatment.</td>
</tr>
</tbody>
</table>
# Chorionic Gonadotropins

## Products Affected
- CHOR GONADOTROPIN, HUM (BULK) POWDER 1 MILLION UNIT, 2 MILLION UNIT, 5 MILLION UNIT
- CHORIONIC GONADOTROPIN, HUMAN
- NOVAREL INTRAMUSCULAR RECON SOLN 10,000 UNIT

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All medically accepted indications not otherwise excluded. Plus patients continuing use for a covered indication.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Authorization will be for 12 months</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For continuation of therapy for all conditions, prescriber attests the patient has a response to treatment.</td>
</tr>
</tbody>
</table>
Cimzia

Products Affected
- CIMZIA
- CIMZIA POWDER FOR RECONST
- CIMZIA STARTER KIT

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on certolizumab pegol for a Covered Use.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Concurrent use with a biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz, Otezla). Moderate or severe heart failure (NYHA Class III or IV). History of treated lymphoproliferative disease. Multiple sclerosis or other demyelinating disorder.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis, concurrent medications, previous therapies tried</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Patients 18 years of age and older.</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>For rheumatoid arthritis (RA) and ankylosing spondylitis (AS) must be prescribed by or in consultation with a rheumatologist. For Psoriatic arthritis (PA), must be prescribed by or in consultation with a rheumatologist or dermatologist. Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist. For Crohn's disease (CD), must be prescribed by or in consultation with a gastroenterologist</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For CD, the patient has tried adalimumab or infliximab for at least 3 months unless the patient experienced intolerance. For RA and AS, the patient must have a trial with etanercept or adalimumab for at least 3 months unless the patient experienced intolerance. For PA and PP, patient has tried at least 2 of the following biologic or target synthetic DMARDs adalimumab, etanercept, infliximab, and apremilast for at least 3 months unless the patient experienced intolerance. For continuation of therapy for all conditions, prescriber attests the patient has had a response to treatment.</td>
</tr>
</tbody>
</table>
# Cinqair

**Products Affected**
- CINQAIR

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted indications not excluded from coverage.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concurrent use with Xolair or Nucala</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>18 years of age and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with an allergist, immunologist, or pulmonologist</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td>Other Criteria</td>
<td>Initial therapy, approve if the patient meets all of the following criteria: 1) must have peripheral blood eosinophil count of greater than or equal to 400 cells per microliter within the previous 4 weeks (prior to treatment with Cinqair), AND 2) pt has received at least 3 consecutive months of combination therapy with an inhaled corticosteroid and ONE of the following: inhaled LABA, inhaled long-acting muscarinic antagonist, leukotriene receptor antagonist, or theophylline, AND 3) Pt's asthma continues to be uncontrolled as defined by ONE of the following: patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, or patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year, or patient has a FEV1 less than 80 percent predicted, or Patient has an FEV1/FVC less than 0.80, or Patient's asthma worsens upon tapering of oral corticosteroid therapy. Continuation therapy, approve if the patient meets all of the following criteria: 1) The patient has responded to Cinqair therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations, decreased asthma symptoms, decreased hospitalizations, emergency department (ED)/urgent care, or physician visits due to asthma, decreased requirement for oral corticosteroid therapy), AND 2) Patient continues to receive therapy with BOTH an inhaled corticosteroid and ONE of the following: inhaled LABA, inhaled long-acting muscarinic antagonist, leukotriene receptor antagonist, or theophylline.</td>
</tr>
</tbody>
</table>
## Crysvita

### Products Affected
- CRYSVITA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Chronic Kidney Disease (CKD), Severe Renal Impairment or End Stage Renal Disease</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, lab values</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with a endocrinologist or nephrologist</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Approve if the patient has had a baseline (i.e., prior to any XLH treatment [e.g., Crysvita, oral phosphate/vitamin D therapy]) serum phosphorus level that was below the normal range for age. Continuation Therapy - Patient must have responded, as determined by the prescriber.</td>
</tr>
</tbody>
</table>
## DUOPA

### Products Affected

- DUOPA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted indications not otherwise excluded plus those already started on Duopa for a covered use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Patients who are currently taking a nonselective monoamine oxidase (MAO) inhibitor (e.g., phenelzine and tranylcypromine) or have recently (within 2 weeks) taken a nonselective MAO inhibitor</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, medication history</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with a neurologist or a provider specializing in the treatment of Parkinson's disease (PD).</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 12 months</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Advanced Parkinson's disease (PD) with complicated motor fluctuations that have not been adequately controlled with oral levodopa-carbidopa AND dopamine agonist AND catechol-O-methyl transferase (COMT) inhibitor OR Monoamine oxidase B (MAO-B) inhibitor. For continuation of therapy for all conditions, prescriber attests the patient has a response to treatment.</td>
</tr>
</tbody>
</table>
## Entyvio

### Products Affected

- ENTYVIO

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<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted indications not otherwise excluded plus patients already started on vedolizumab for a covered use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concurrent use with a biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz, Otezla).</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, previous medication use</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Patients 18 years of age and older.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>For Crohn's disease (CD) and ulcerative colitis (UC), prescribed by or in consultation with a gastroenterologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For CD and UC, the patient has tried adalimumab or infliximab for at least 3 months unless the patient experienced intolerance. For continuation of therapy for all conditions, prescriber attests the patient has had a response to treatment.</td>
</tr>
</tbody>
</table>
## Exondys 51

### Products Affected
- EXONDYS 51

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, prescriber specialty</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>14 years or younger for new starts</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy (DMD) and/or neuromuscular disorders</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 1 year.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Member has a confirmed mutation of the DMD gene amenable to exon 51 skipping and Eteplirsen has been initiated in childhood (before 14 years of age) and Member is able to achieve an average distance of at least 180m while walking independently over six minutes</td>
</tr>
</tbody>
</table>
### Fasenra

**Products Affected**
- FASENRA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
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<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted indications not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concurrent use with Xolair or another IL Antagonist Monoclonal Antibody</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, severity of disease, peripheral blood eosinophil count, previous therapies tried and current therapies, FEV1/FVC</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>12 years of age and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with an allergist, immunologist, or pulmonologist</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization for 1 year, continuation 3 years</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Asthma in Patients with Severe Disease and an Eosinophilic Phenotype - Initial Therapy: Approve Fasenra if the patient meets the following criteria patient has a blood eosinophil count of greater than or equal to 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with any interleukin (IL)-5 antagonist monoclonal antibody (e.g., Fasenra, Nucala, Cinqair) AND Patient has received at least 3 consecutive months of combination therapy with BOTH of the following an inhaled corticosteroid (ICS), AND At least ONE of the following Inhaled long-acting beta2-agonist (LABA) OR Inhaled long-acting muscarinic antagonist (LAMA) OR Leukotriene receptor antagonist (LTRA) OR Theophylline AND Patient's asthma is uncontrolled or was uncontrolled prior to starting any IL-antagonist therapy according to prescribing physician. Continuing Approve if the patient meets the following criteria patient has already received Fasenra AND Patient continues to receive therapy with one inhaled corticosteroid (ICS) or one ICS-containing combination inhaler AND The patient has responded to Fasenra therapy as determined by the prescribing physician</td>
</tr>
</tbody>
</table>
## Fibryga

### Products Affected
- FIBRYGA

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<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>1 year for initial treatment, 3 years for continuation.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Continuation Therapy - prescriber attests the patient has shown a response to treatment.</td>
</tr>
</tbody>
</table>
### Products Affected
- HEMLIBRA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted and FDA-approved indications not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Prescriber specialty, patient medical history.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with a hemophilia specialist</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Approval duration of 1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>The patient has factor VIII inhibitors or a history of factor VIII inhibitors. Continuation Therapy - Patient must have responded, as determined by the prescriber.</td>
</tr>
</tbody>
</table>
## Ilumya

### Products Affected
- ILUMYA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted indications not otherwise excluded plus patients already started on Ilumya for a covered use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concurrent use with a biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz, Otezla).</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, previous medication use</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Patients 18 years of age and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>PP, patient has tried at least 2 of the following biologic or target synthetic DMARDs: adalimumab, etanercept, infliximab, and apremilast for at least 3 months unless the patient experienced intolerance. Continuation Therapy - Patient must have responded, as determined by the prescriber</td>
</tr>
</tbody>
</table>
# Kanuma

## Products Affected

- KANUMA

## PA Criteria

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted indications not excluded from coverage.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 12 months</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Kymriah

**Products Affected**
- Kymriah

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved and NCCN supported indications not otherwise excluded from coverage: Diffuse large B-cell lymphoma, Relapsed or refractory, following 2 or more lines of systemic therapy Pre B-cell acute lymphoblastic leukemia, Refractory or in second or later relapse</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Investigational use, prior CAR-T therapy use</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Documentation of screening for HBV, HCV and HIV before collection of cells for manufacturing of Kymriah therapy. Results of screening indicate the absence of active or latent hepatitis B, active hepatitis C, and active HIV. Documentation of any live vaccine use in the 6 weeks prior to therapy.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Pre B-cell acute lymphoblastic leukemia, Refractory or in second or later relapse, 25 years and under. Diffuse large B-cell lymphoma, Relapsed or refractory, following 2 or more lines of systemic therapy, 18 years of age and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Healthcare facility is enrolled as a certified treatment center and has enrolled in Kymriah REMS program</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization for 1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Lemtrada

### Products Affected
- LEMTRADA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically-approved indications not otherwise excluded. Plus patients continuing use of the product for a covered indication.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>The patient has a relapsing form of MS (relapsing forms of MS are RRMS, SPMS with relapses, and PRMS)</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>The patient is 17 years of age or older.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Lemtrada is prescribed by or in consultation with a neurologist or a physician that specializes in the treatment of MS.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>The patient has had an inadequate response according to the prescribing physician to two of the following medications for MS: Avonex, Rebif, Betaseron, Extavia, Copaxone, Plegridy, Gilenya, Aubagio, Tecfidera, or Tysabri. For continuation of therapy for all conditions, prescriber attests the patient has a response to treatment.</td>
</tr>
</tbody>
</table>
### Libtayo

#### Products Affected
- LIBTAYO

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from coverage. Plus patients already started on Libtayo for a covered use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, previous surgeries or radiation</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with an oncologist</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 1 year.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Locally advanced or metastatic CSCC-approve if the patient is not a candidate for curative surgery or curative radiation.</td>
</tr>
</tbody>
</table>
## Lumoxiti

**Products Affected**
- LUMOXITI

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Lumoxiti for a covered use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, previous therapies</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Hairy cell leukemia - approve if the patient has tried two prior therapies, including treatment with a purine nucleoside analog.</td>
</tr>
</tbody>
</table>
## Lutathera

### Products Affected
- LUTATHERA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted indications not otherwise excluded</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Diagnosis, prior drugs tried, results of somatostatin receptor test, pregnancy status, prescriber licensed to use radiopharmaceuticals by an appropriate governmental agency</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescriber licensed to use radiopharmaceuticals by an appropriate governmental agency</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Approval duration for 1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Initial therapy - The patient has locally advanced, inoperable, or metastatic carcinoid tumor AND The patient progressed on somatostatin analogs AND The patient will discontinue long-acting somatostatin analog for at least 4 weeks prior to initiating the requested agent AND Documentation confirming the tumor was somatostatin receptor-positive Lutathera dose AND The requested dose is within FDA-labeled dosing for the requested indication AND The patient has NOT exceeded 4 treatment doses in lifetime. Continuation of therapy There is documentation that AND During Lutathera treatment, Sandostatin LAR Depot 30 mg should be administered intramuscularly (IM) between 4 to 24 hours after each the patient is currently being treated with the requested agent AND The patient has NOT exceeded 4 treatment doses in lifetime.</td>
</tr>
</tbody>
</table>
Luxturna

Products Affected
- LUXTURNA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All medically accepted indications not otherwise excluded.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>12 months of age or older. Up to age 65.</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by, or in consultation with an ophthalmologist or retinal specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Authorization will be for a one-time use.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Approve for one-time treatment in each eye if the patient meets the following criteria. A) According to the prescribing physician, the patient has a genetically-confirmed diagnosis of biallelic RPE65 mutation-associated retinal dystrophy, AND B) Patient must have viable retinal cells as determined by the treating physician.</td>
</tr>
</tbody>
</table>
# Lysosomal Storage Disease Enzyme Replacement Therapies

## Products Affected

- ALDURAZYME
- CEREZYME INTRAVENOUS RECON SOLN 400 UNIT
- ELAPRASE
- ELELYSO
- FABRAZYME
- LUMIZYME
- NAGLAZYME
- VPRIV

## PA Criteria

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All medically accepted indications not excluded from coverage.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Lumizyme: 8 years of age or older</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Authorization will be for 12 months</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Lumizyme Initial treatment must meet all of the following: The member has a diagnosis of late-onset (noninfantile) Pompe disease. The member's diagnosis of late-onset Pompe disease is based on both of the following: Acid alpha-glucosidase (GAA) enzyme assay that shows reduced enzyme activity at less than 40 percent of the lab-specific normal mean value AND Confirmation by a second GAA enzyme activity assay in a separate sample (from purified lymphocytes, fibroblast, or muscle) or by GAA gene sequencing. The member has a forced vital capacity (FVC) 30 percent to 79 percent of predicted value while in the sitting position, The member has a postural drop in FVC (in liters) of 10 percent or more from upright to supine position, The member has the ability to walk 40 meters on a six minute walk test (assistive devices permitted), AND The member has muscle weakness in the lower extremities. Continuation: The clinical criteria for approval of a subsequent PA request for Lumizyme are both of the following: The member is ambulatory (assistive devices permitted) The member is not ventilator dependent. Note: The prescriber should indicate the member’s ambulation and ventilator status on the PA request. Continuation for other therapies - prescriber attests the patient has had a response to treatment.</td>
</tr>
</tbody>
</table>
Mepsevii

Products Affected

- MEPSEVII

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All medically accepted indications not otherwise excluded.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>1 year for initial treatment, 3 years for continuation.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Continuation Therapy - prescriber attests the patient has shown a response to treatment.</td>
</tr>
</tbody>
</table>
## Nucala

### Products Affected
- NUCALA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted indications not excluded from coverage.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concurrent use with Xolair</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>12 years of age and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with an allergist, immunologist, pulmonologist</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Initial - must have peripheral blood eosinophil count of greater than or equal to 150 cells per microliter within the previous 6 weeks (prior to treatment with Nucala) AND Patient has received at least 3 consecutive months of combination therapy with an inhaled corticosteroid AND one of the following A. inhaled LABA, B. inhaled long-acting muscarinic antagonist, C. Leukotriene receptor antagonist, or D. Theophylline. Patient's asthma continues to be uncontrolled as defined by ONE of the following - patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year, patient has a FEV1 less than 80 percent predicted, Patient has an FEV1/FVC less than 0.80, or Patient's asthma worsens upon tapering of oral corticosteroid therapy. Continuation-The patient has responded to Nucala therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations, decreased asthma symptoms, decreased hospitalizations, emergency department (ED)/urgent care, or physician visits due to asthma, decreased requirement for oral corticosteroid therapy) AND Patient continues to receive therapy with an inhaled corticosteroid.</td>
</tr>
</tbody>
</table>
## Ocrevus

### Products Affected
- OCREVUS

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>18 years of age and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by, or in consultation with, a physician who specializes in the treatment of MS and/or a neurologist</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
Onpattro

Products Affected
• ONPATTRO

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved or medically accepted indications not otherwise excluded from coverage</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>18 years of age and older</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a neurologist, geneticist, or a physician who specializes in the treatment of amyloidosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Authorization will be for 1 year. Continuation for 1 year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Approve if the patient has a documented transthyretin (TTR) mutation verified by genetic testing AND the patient has symptomatic peripheral neuropathy (e.g., reduced motor strength/coordination, impaired sensation [e.g., pain, temperature, vibration, touch]). Continuation Therapy: prescriber attests the patient has had a response to treatment.</td>
</tr>
</tbody>
</table>
### Orencia IV

**Products Affected**
- ORENCIA (WITH MALTOSE)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically-accepted indications not otherwise excluded plus patients who have already been started on abatacept for a covered use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concurrent use with a biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz, Otezla).</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, previous medication use</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Rheumatoid arthritis (RA) and Psoriatic arthritis (PA), patients 18 years of age and older. Juvenile idiopathic arthritis (JIA), patient 2 years of age and older.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>RA and JIA/JRA prescribed by or in consultation with a rheumatologist. For Psoriatic arthritis (PA), must be prescribed by or in consultation with a rheumatologist or dermatologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For RA, the patient must have a trial with etanercept or adalimumab for at least 3 months unless the patient experienced intolerance. For JIA, approve abatacept IV only if the patient has tried adalimumab or etanercept (abatacept SC is not FDA-approved for the treatment of JIA/JRA). For Juvenile Rheumatoid Arthritis (JRA), approve abatacept IV only if the patient has tried adalimumab or etanercept for at least 2 months or was intolerant to one of these therapies (abatacept SC is not FDA-approved for the treatment of JIA/JRA). For PA, patient has tried at least 2 of the following biologic or target synthetic DMARDs: adalimumab, etanercept, infliximab, and apremilast for at least 3 months unless the patient experienced intolerance For continuation of therapy for all conditions, prescriber attests the patient has had a response to treatment.</td>
</tr>
</tbody>
</table>
# Poteligeo

## Products Affected
- POTELIGEO

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded. Plus patients already started on Poteligeo for a covered use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, prior therapies</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by, or in consultation with an oncologist or dermatologist</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Approve if the patient has relapsed or refractory disease and has received at least one prior systemic therapy. Continuation Therapy - Patient must have responded, as determined by the prescriber.</td>
</tr>
</tbody>
</table>
Programmed Death Receptor/Ligand Pathway Inhibitors

Products Affected
- BAVENCIO 100 MG/10 ML, 40 MG/4 ML
- IMFINZI
- KEYTRUDA INTRAVENOUS SOLUTION
- OPDIVO INTRAVENOUS SOLUTION
- TECENTRIQ INTRAVENOUS SOLUTION 1,200 MG/20 ML (60 MG/ML)

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All medically accepted indications not excluded from coverage.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Provenge

### Products Affected
- PROVENGE

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically-accepted indications not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Coverage duration of 12 months</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Documentation to support patient is asymptomatic or minimally symptomatic and has metastatic castrate resistant (hormone refractory) disease AND Patient's testosterone levels less than 50 ng/dl.</td>
</tr>
</tbody>
</table>
# Radicava

## Products Affected
- RADICAVA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted and FDA-approved indications not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>ALSFRS-R score, FVC %, Time elapsed since diagnosis</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by, or in consultation with a neurologist, a neuromuscular disease specialist, or a physician specializing in the treatment of ALS</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 6 months. Continuation - Authorization will be for 12 months.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>ALS initial therapy - approve if the patient meets ALL of the following criteria. 1) According to the prescribing physician, the patient has a definite or probable diagnosis of ALS, AND 2) The patient has a score of two points or more on each item of the ALS Functional Rating Scale - Revised (ALSFRS-R) [ie, has retained most or all activities of daily living], AND 3) The patient has a FVC greater than or equal to 80% (ie, normal respiratory function), AND 4) The Patient has been diagnosed with ALS for less than or equal to 2 years. ALS continuation therapy - approve if, according to the prescribing physician, the patient continues to benefit from therapy AND the patient is not requiring invasive ventilation.</td>
</tr>
</tbody>
</table>
Remodulin

Products Affected
- REMODULIN

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically-accepted indications not otherwise excluded. Plus patients continuing use of the product for a covered indication.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>PAH WHO group, right heart catheterization results, WHO functional status, previous drugs tried.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>PAH WHO Group 1, prescribed by or in consultation with a cardiologist or a pulmonologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 12 months.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>PAH WHO Group 1, patients not currently on Remodulin pt required to have had a right-heart catheterization to confirm the diagnosis of PAH (mPAP greater than 25 mm Hg at rest, PCWP equal to or less than 15 mm Hg, and PVR greater than 3 Wood units) AND either have functional Class III or IV, OR have functional Class II and meet ONE of the following a. tried or is currently receiving one oral agent for PAH (e.g., Tracleer, Letairis, Opsumit, Adempas, Revatio, Adcirca, or Orenitram) or unable to take any of the agents above (e.g., those with liver abnormalities (Tracleer), women of childbearing potential (Tracleer, Letairis), concomitant use with nitrates(sildenafil, Cialis), hypotension, drug-drug interactions) OR b. tried one inhaled or parenteral prostacyclin product for PAH (e.g., Ventavis, Tyvaso, epoprostenol injection) AND if the pt has idiopathic PAH, they must have one of the following: 1. had an acute response to vasodilator testing that occurred during the right heart cath (defined as decrease in mPAP of at least 10 mm Hg to an absolute mPAP of less than 40 mm Hg without a decrease in cardiac output) AND has tried an oral CCB (e.g. amlodipine, nifedipine extended-release tablets) or 2. pt did not have an acute response to vasodilator testing or 3. cannot undergo vasodilator test or cannot take CCB due to right heart failure or decreased cardiac output or 4. has tried a CCB. PAH WHO Group1, patients currently on Remodulin- pt must have had a right heart catherization to confirm the diagnosis of PAH. For continuation of therapy for all conditions, prescriber attests the patient has had a response to treatment.</td>
</tr>
</tbody>
</table>
## Simponi Aria

### Products Affected

- SIMPONI ARIA

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted indications not otherwise excluded plus patients who have already been started on golimumab (IV) for a covered use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concurrent use with a biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz, Otezla). Moderate or severe heart failure (NYHA Class III or IV). History of treated lymphoproliferative disease. Multiple sclerosis or other demyelinating disorder.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, previous medication use</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Rheumatoid arthritis (RA), Psoriatic arthritis (PA), Ankylosing Spondylitis (AS), and Plaque Psoriasis (PP), patients 18 years of age and older.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>RA and AS prescribed by or in consultation with a rheumatologist. For Psoriatic Arthritis (PA) must be prescribed by or in consultation with a rheumatologist or a dermatologist. For Plaque Psoriasis (PP) must prescribed by or in consultation with a dermatologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For RA and AS, the patient must have a trial with etanercept or adalimumab for at least 3 months unless the patient experienced intolerance. For PA and PP, patient has tried at least 2 of the following biologic or target synthetic DMARDs: adalimumab, etanercept, infliximab, and apremilast for at least 3 months unless the patient experienced intolerance. For continuation of therapy for all conditions, prescriber attests the patient has had a response to treatment.</td>
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## Soliris

**Products Affected**
- SOLIRIS

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<td>All medically accepted indications not excluded from coverage.</td>
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<tr>
<td><strong>Exclusion Criteria</strong></td>
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</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis</td>
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<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 12 months</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
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## Spinraza

### Products Affected
- SPINRAZA (PF)

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<th>Criteria Details</th>
</tr>
</thead>
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<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>The medication is prescribed by or in consultation with a physician who specializes in the management of patients with spinal muscular atrophy and/or neuromuscular disorders</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Spinal Muscular Atrophy - meets all of the following criteria - The patient has type I, II or III spinal muscular atrophy AND The patient has had a genetic test confirming the diagnosis of spinal muscular atrophy (homozygous gene deletion, homozygous mutation, or compound heterozygous mutation)</td>
</tr>
</tbody>
</table>
## Stelara

### Products Affected

- STELARA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted indications not otherwise excluded plus patients already started on ustekinumab for a covered use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concurrent use with a biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz, Otezla).</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, previous medication use</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Patients 18 years of age and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist. Psoriatic Arthritis (PA), prescribed by or in consultation with a rheumatologist or dermatologist. Crohn's Disease (CD), prescribed by or in consultation with a gastroenterologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For PA and PP, patient has tried at least 2 of the following biologic or target synthetic DMARDs: adalimumab, etanercept, infliximab, and apremilast for at least 3 months unless the patient experienced intolerance. For CD, the patient has tried adalimumab or infliximab for at least 3 months unless the patient experience intolerance. For SQ formulation, must have received or will receive a single IV induction dose. For continuation of therapy for all conditions, prescriber attests the patient has had a response to treatment.</td>
</tr>
</tbody>
</table>
## Tremfya

### Products Affected
- TREMFYA SUBCUTANEOUS SYRINGE

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted and FDA-approved indications not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, Previous medication use</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>18 years of age or older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by, or in consultation with a dermatologist</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 3 months. Continuation - Authorization will be for 3 years.</td>
</tr>
</tbody>
</table>
| **Other Criteria**        | Initial Therapy - Approve if the patient has tried TWO of the following Enbrel, Humira, Stelara SC, Otezla or Cosentyx.  
                          | Continuation Therapy - Patient must have responded, as determined by the prescriber.                                                               |
Tysabri

Products Affected
• TYSABRI

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All medically accepted indications not otherwise excluded. Plus patients already started on Tysabri for a Covered Use.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>CD - Concurrent Use of Tysabri with an Immunosuppressant Agent in Patients with Crohn's Disease. MS - Current Use of Tysabri with Other Disease-Modifying Agents or immunosuppressants used for MS. Per warning and precautions, coverage is not provided for immune compromised patients with MS or CD.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Adults with MS. Patient has a relapsing form of MS (relapsing forms of MS are relapsing remitting [RRMS], secondary progressive [SPMS] with relapses, and progressive relapsing [PRMS]).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Patients 18 years of age and older</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>MS. Prescribed by, or in consultation with, a neurologist or physician who specializes in the treatment of MS. CD. Prescribed by or in consultation with a gastroenterologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Adults with a relapsing form of MS. Patient has had an inadequate response to, or is unable to tolerate, therapy with at least one of the following MS medications: interferon beta-1a (Avonex, Rebif), interferon beta-1b (Betaseron, Extavia), glatiramer acetate (Copaxone/Glatopa), Plegridy, fingolimod (Gilenya), Tecfidera, Lemtrada, or Aubagio OR the patient has highly active or aggressive disease according to the prescribing physician. Adults with CD. Patient has tried two biologics for CD for at least 3 months each (eg., adalimumab, certolizumab, ustekinumab, or infliximab) and had an inadequate response or was intolerant. For continuation of therapy for all conditions, prescriber attests the patient has had a response to treatment.</td>
</tr>
</tbody>
</table>
# Vyxeos

**Products Affected**
- VYXEOS

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically accepted indications not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by, or in consultation with an oncologist or hematologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>1 year for initial treatment, 3 years for continuation.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Continuation Therapy - prescriber attests the patient has shown a response to treatment.</td>
</tr>
</tbody>
</table>
## Xgeva

### Products Affected
- XGEVA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically-accepted indications not otherwise excluded. Plus patients continuing use of the product for a covered indication.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Xolair

### Products Affected
- XOLAIR SUBCUTANEOUS RECON SOLN

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All medically-accepted indications not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, previous medications, baseline IgE level, allergen test results</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Patient is 6 years of age or older.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>For Asthma in Patients with Moderate to Severe Persistent Disease and Allergic Rhinitis, Seasonal or Perennial must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist. For Chronic Idiopathic Urticaria (Chronic Spontaneous Urticaria) must be prescribed by or in consultation with an allergist, immunologist, or dermatologist. For Eosinophilic Gastroenteritis (EG) must be prescribed by or in consultation with an allergist, immunologist, or gastroenterologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - Authorization will be for 1 year. Continuation - Authorization will be for 3 years.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Asthma in Patients with Moderate to Severe Persistent Disease Patient must meet the following: Baseline IgE level is greater than or equal to 30 IU/mL, AND The patient has a baseline positive skin test or in vitro testing (i.e., a blood test for allergen-specific IgE antibodies such as an enzyme-linked immunoabsorbant assay [e.g., ImmunoCAP™, ELISA] or the radioallergosorbent test [RAST]) for one or more perennial aeroallergens (e.g., house dust mite [Dermatophagoides farinae, D. pteronyssinus], animal dander [dog, cat], cockroach, feathers, mold spores), AND/OR for one or more seasonal aeroallergens (grass, pollen, weeds) AND The patient's asthma symptoms have not been adequately controlled, as determined by the prescriber, by at least 3 months of therapy with inhaled corticosteroids taken in combination with one of the following agents: A long-acting beta agonist (LABA) OR If the patient has a contraindication or intolerance to use of LABAs, sustained-release theophylline or leukotriene modifier (e.g., montelukast). For Chronic Idiopathic Urticaria (Chronic Spontaneous Urticaria) approve if the patient meets the following: Patient has urticaria for greater than 6 weeks, with symptoms present greater than 3 days per week despite daily non-sedating H1-antihistamine therapy with doses that have been titrated up to a maximum of four times the standard FDA-approved dose AND Patient has tried therapy with a leukotriene modifier (e.g., montelukast) with a daily non-sedating H1 antihistamine. Allergic Rhinitis, Seasonal or Perennial approve if the patient meets the following Baseline IgE level of greater than or equal to 30 IU/mL AND Patient has seasonal or perennial allergic rhinitis as demonstrated by baseline positive skin testing (e.g., grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach) AND/OR baseline positive in vitro testing (i.e., a blood test for allergen-specific IgE antibodies) for one or more relevant allergens (e.g., grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach) AND Patient meets one of the following: Patient has tried therapy with at least one drug from two</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>of the following groups of drugs at the same time: A non-sedating or low-sedating H1 antihistamine[Rx or OTC] OR a nasal antihistamine, A nasal corticosteroid, or Montelukast OR Patient must have tried therapy with at least one drug from all 3 of the above groups individually or in any combination during one allergy season (i.e., 6 months). Eosinophilic Gastroenteritis (EG), Eosinophilic Esophagitis (EE), or Eosinophilic Colitis approve if the patient meets the following: Patient has tried therapy with a systemic or oral administered topical corticosteroid AND Diagnosis has been confirmed based on biopsy showing greater than or equal to 15 eosinophils per high-power field. Continuing Xolair: approve if request meets prescriber restrictions AND patient has responded to therapy as determined by the prescriber.</td>
<td></td>
</tr>
</tbody>
</table>
Yervoy

Products Affected
• YERVOY

<table>
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<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All medically-accepted indications not otherwise excluded</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
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<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approval will be for 1 year</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Yescarta

### Products Affected
- Yescarta

<table>
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<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved and NCCN supported indications not otherwise excluded from coverage: B-cell lymphoma, Large, relapsed or refractory, after 2 or more lines of systemic therapy</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Investigational use, prior CAR-T therapy use</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Documentation of screening for HBV, HCV and HIV before collection of cells for manufacturing of Yescarta therapy. Results of screening indicate the absence of active or latent hepatitis B, active hepatitis C, and active HIV. Documentation of any live vaccine use in the 6 weeks prior to therapy</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>B-cell lymphoma, Large, relapsed or refractory, after 2 or more lines of systemic therapy, 18 years of age or older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Healthcare facility is enrolled as a certified treatment center and has enrolled in Yescarta REMS program</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for one year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
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<td>NOVAREL INTRAMUSCULAR RECON SOLN 10,000 UNIT</td>
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<td>OPDIVO INTRAVENOUS SOLUTION 100 MG/10 ML, 40 MG/4 ML</td>
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<td>ORENCIA (WITH MALTOSE)</td>
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<td>TECENTRIQ INTRAVENOUS SOLUTION 1,200 MG/20 ML (60 MG/ML)</td>
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