2020 PRIOR AUTHORIZATION CRITERIA
UCare Connect (SNBC)
MinnesotaCare
Prepaid Medical Assistance Program (PMAP)
Minnesota Senior Care Plus (MSC+)

UCare requires your physician to get prior authorization for certain drugs. This means that you will need to get approval from UCare before you fill your prescriptions. If you don’t get approval, UCare may not cover the drug.

UCare PMAP, MinnesotaCare, and MSC+ members with questions should call UCare Customer Service at 1-800-203-7225 toll free. UCare Connect members with questions should call 1-877-903-0061 toll free. TTY machine users can call 1-800-688-2534. Hours of operation are 8 am - 5 pm, Monday - Friday.

Effective: 05/01/2020

U6429 (05/2020)
# Actemra

## Products Affected
- ACTEMRA SUBCUTANEOUS

<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 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 and other medications tried for the diagnosis provided</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.</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>Authorization will be for 12 months.</td>
</tr>
<tr>
<td><strong>PA Criteria</strong></td>
<td><strong>Criteria Details</strong></td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></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, 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, 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>
## Afinitor

### Products Affected
- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG
- everolimus (antineoplastic)

<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. Advanced, unresectable neuroendocrine tumors. Perivascular Epitheloid Cell Tumors (PEComa), Recurrent Angiomyolipoma, Lymphangioleiomyomatosis, relapsed or refractory classical Hodgkin lymphoma, Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma (WM/LPL), Advanced Breast Cancer in Patients with HER2-negative Disease Already Started on Afinitor Therapy, Differentiated (i.e. papillary, follicular, and Hürthle cell) Thyroid Carcinoma, Osteosarcoma, Thymomas and Thymic Carcinmoas</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>HER2 status. Advanced HER2-negative breast cancer, hormone receptor (HR) status.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Classical Hodgkins Lymphoma patients are 18 years or older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 3 years.</td>
</tr>
<tr>
<td><strong>PA Criteria</strong></td>
<td><strong>Criteria Details</strong></td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Advanced HER2-negative breast cancer, approve if the patient is a postmenopausal woman and has HR+ disease and Afinitor will be used in combination with exemestane or tamoxifen and the patient has tried letrozole, tamoxifen or anastrozole. Renal cell carcinoma (RCC), approve if patient meets one of the following: 1) patient has advanced RCC with predominant clear cell histology AND the patient has tried Inlyta, Votrient, Sutent, or Nexavar OR 2) patient has relapsed or medically unresectable RCC with non-clear cell histology. Tuberous sclerosis complex (TSC) for the treatment of subependymal giant cell astrocytoma (SEGA), approve if the patient requires therapeutic intervention but cannot be curatively resected. NET-approve. Osteosarcoma, approve if the patient has tried standard chemotherapy for osteosarcoma AND the patient has relapsed/refractory or has metastatic disease. Thymomas and Thymic Carcinomas, approve if the patient has tried chemotherapy. Renal angiomyolipoma with TSC-approve. WM/LPL - approve if 1. patient has progressive or relapsed disease OR 2. patient has not responded to primary therapy (e.g., Velcade+/- Rituxan, Velcade with dexamethasone +/-Rituxan, Kyprolis with Rituxan and dexamethasone, cyclophosp/doxorubicin/vincristine/pred/Rituxan, Imbruvica, Rituxan, Rituxan with cyclophosphamide and dexamethasone, Thalomid+/- Rituxan OR pt has progressive or relapsed disease.</td>
</tr>
</tbody>
</table>
# Alecensa

## Products Affected
- ALECENSA

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<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indication not otherwise excluded.</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></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>Metastatic NSCLC - is anaplastic lymphoma kinase (ALK)-positive AND has either progressed on or is intolerant to Xalkori, or is being used as first-line therapy.</td>
</tr>
</tbody>
</table>
Alunbrig

Products Affected

• ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
• ALUNBRIG ORAL TABLETS, DOSE PACK

<table>
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<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indication not otherwise excluded.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>ALK status, treatment history and results</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 3 years.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Metastatic NSCLC, patient new to therapy must be ALK-positive AND experienced progression or intolerance while on Xalkori, Zykadia or Alecensa</td>
</tr>
</tbody>
</table>
# Amifampridine

## Products Affected
- FIRDAPSE
- RUZURGI

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA approved indication not otherwise excluded</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>History of seizures (initial therapy)</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, seizure history, lab and test results</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Firdapse - 18 years of age or older Ruzurgi - 6 years of age or older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with a neurologist or a neuromuscular specialist (initial therapy)</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial-3 months, Cont-1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Initial therapy-Diagnosis confirmed by at least one electrodiagnostic study (e.g., repetitive nerve stimulation) OR anti-P/Q-type voltage-gated calcium channels (VGCC) antibody testing according to the prescribing physician. Continuation-patient continues to derive benefit (e.g., improved muscle strength, improvements in mobility) from Firdapse/Ruzurgi, according to the prescribing physician.</td>
</tr>
</tbody>
</table>
### Ampyra

**Products Affected**
- dalfampridine

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<tr>
<th>PA Criteria</th>
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<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></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>Prescribed by or in consultation with a neurologist or a physician who 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>Used to improve mobility in a patient with MS.</td>
</tr>
</tbody>
</table>
## Anabolic Steroids

### Products Affected
- oxandrolone

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded. Girls w/ Turner’s Syndrome or Ullrich-Turner Syndrome (oxandrolone only), management of protein catabolism w/burns or burn injury (oxandrolone only), AIDS wasting and cachexia.</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></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 12 months, unless otherwise specified.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
**ARIKAYCE**

**Products Affected**
- ARIKAYCE

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indication not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, previous medication history</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>18 years and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by a pulmonologist, infectious disease physician or a physician who specializes in the treatment of MAC lung infections</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>MAC Lung disease-approve if the patient has NOT achieved negative sputum cultures for Mycobacterium avium complex after greater than or equal to 6 consecutive months of a background multidrug regimen AND Arikayce will be used in conjunction to a background multidrug regimenNote-a multidrug regimen typically includes a macrolide (azithromycin or clarithromycin), ethambutol and a rifamycin (rifampin or rifabutin)</td>
</tr>
</tbody>
</table>
# Austedo

## Products Affected
- AUSTEDO

<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, previous medications tried</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 psychiatrist</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>Chorea associated with Huntington’s Disease - approve if, according to the prescribing physician, the patient has previously tried brand or generic tetrabenazine tablets.</td>
</tr>
</tbody>
</table>
# Balversa

## Products Affected
- BALVERSA

<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.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, previous therapies, test results</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 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Urothelial Carcinoma, locally advanced or metastatic- Approve if the patient has susceptible fibroblast growth factor receptor 3 or fibroblast growth factor receptor 2 genetic alterations AND the patient has progressed during or following prior platinum-containing chemotherapy (i.e., cisplatin, oxaliplatin).</td>
</tr>
</tbody>
</table>
## Berinert

**Products Affected**
- BERINERT

<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 indication not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Lab values (C1-INH protein, serum C4)</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 allergist/immunologist or a provider that specializes in the treatment of hereditary angioedema or related disorders</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>Hereditary angioedema confirmed by low levels of functional C1-INH protein (less than 50% of normal) at baseline and confirmed by lower than normal serum C4 levels at baseline. Continuation of therapy, must have had favorable clinical response (for example, decrease in number of HAE acute attack frequency, decrease in HAE attack severity, decrease in duration of HAE attacks) since initiating Berinert compared with baseline.</td>
</tr>
</tbody>
</table>
## Bexarotene

### Products Affected
- bexarotene

<table>
<thead>
<tr>
<th>PA Criteria</th>
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<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded.</td>
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<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>
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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 1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Bosulif

**Products Affected**
- BOSULIF

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded. Plus patients already started on Bosulif 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 for which Bosulif is being used. For chronic myelogenous leukemia (CML), the Philadelphia chromosome (Ph) status of the leukemia must be reported. For CML, prior therapies tried must be reported to confirm resistance or intolerance.</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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For CML, patient must have Ph-positive CML and have tried one other tyrosine kinase inhibitor indicated for use in Philadelphia chromosome positive CML (e.g., Gleevec® [imatinib tablets] Sprycel® [dasatinib tablets], or Tasigna® [nilotinib capsules]).</td>
</tr>
</tbody>
</table>
# Braftovi

**Products Affected**
- BRAFTOVI

## PA Criteria | Criteria Details
--- | ---
**Covered Uses** | All FDA-approved indication not otherwise excluded. Plus patients already started on Braftovi for a covered use.

## Exclusion Criteria

## Required Medical Information
- Diagnosis, BRAF V600 mutations

## Age Restrictions

## Prescriber Restrictions

## Coverage Duration
- Approval duration of 3 years

## Other Criteria
- For unresectable or metastatic malignant melanoma with BRAF V600E or V600K mutation. Must prescribed in combination with Mektovi.
**Brukinsa**

**Products Affected**
- BRUKINSA

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<tr>
<td><strong>Covered Uses</strong></td>
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</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, prior treatment regimens</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>3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Approve if the patient has a diagnosis of mantle cell lymphoma AND the patient has tried at least one prior therapy (e.g. Calquence, Imbruvica with or without a rituximab product, Revlimid with or without a rituximab product, Venclexta with or without a rituximab product, RDHA (a rituximab product, dexamethasone, cytarabine) plus platinum (carboplatin, cisplatin, oxaliplatin), alternating RCHOP (a rituximab product, cyclophosphamide, doxorubicin, vincristine, prednisone)/RDHAP (a rituximab product, dexamethasone, cytarbine, cisplatin), Treanda plus a rituximab product, RCHOP, NORDIC regimen (dose-intensified induction immunochemotherapy with rituxumab plus cyclophosphamide, vincristine, doxorubicin, prednisone [maxi-CHOP]) alternating with a rituximab product plus high-dose cytarbine), HyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethsone alternating with high-dose methotrexate and cytarabine plus rituximab), and VR-CAP (Velcade, a rituximab product, cyclophosphamide, doxorubicin, and prednisone))</td>
</tr>
</tbody>
</table>
Cablivi

Products Affected
• CABLIVI

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<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>None</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis, concurrent medications</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>18 years and older</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a hematologist</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>3 months</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>aTTP-approve if the patient is currently receiving at least one immunosuppressive therapy. [*Note: The FDA-approved indication for CABLIVI (as of 03/01/19) is for the treatment of adult patients with acquired thrombotic thrombocytopenic purpura (aTTP), in combination with plasma exchange and immunosuppressive therapy.]</td>
</tr>
</tbody>
</table>
# Cabometyx

## Products Affected
- **CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG**

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indication not otherwise excluded. Plus patients with Non-Small Cell Lung Cancer with RET Gene Rearrangements. Plus patients already taking Cabometyx 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, medication history, histology, RET gene rearrangement status</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 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Advance Renal Cell Carcinoma-Patients must meet both 1 AND 2. 1) Patient has RCC with predominant clear-cell histology 2) Patient has tried one tyrosine kinase inhibitor therapy (e.g., Sutent® [sunitinib malate capsules], Votrient® [pazopanib tablets], Inlyta® [axitinib tablets], Nexavar® [sorafenib tosylate tablets]) OR patient has RCC with non-clear cell histology</td>
</tr>
</tbody>
</table>
# Calquence

## Products Affected
- CALQUENCE

## Table of Criteria Details

<table>
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<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Previous medications/therapies tried.</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 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Mantle cell lymphoma-approve if the patient has tried one other therapy (e.g., CALGB regimen [Rituxan (rituximab for intravenous infusion), plus methotrexate with augmented CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone)], hyperCVAD [cyclophosphamide, vincristine, doxorubicin, and dexamethasone alternating with high-dose methotrexate and cytarabine] plus Rituxan, NORDIC regimen [dose-intensified induction immunochemotherapy with Rituxan plus cyclophosphamide, vincristine, doxorubicin, prednisone [maxi-CHOP] alternating with Rituxan plus high-dose cytarabine, alternating RCHOP/RDHAP [Rituxan, cyclophosphamide, doxorubicin, vincristine, prednisone/Rituxan, dexamethasone, cisplatin, cytarabine], Treanda [bendamustine injection for intravenous (IV) use] with or without Rituxan, CHOP plus Rituxan, Revlimid [lenalidomide capsules] plus Rituxan, modified Rituxan-hyperCVAD, Imbruvica [ibrutinib capsules], Revlimid with or without Rituxan, Velcade [bortezomib injection for IV or subcutaneous use], and FC [fludarabine, cyclophosphamide] with or without Rituxan.</td>
</tr>
</tbody>
</table>
# Caprelsa

## Products Affected
- CAPRELSA

<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 Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma and NSCLC with RET Gene Rearrangements.</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></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>MTC - approve. DTC - approve if refractory to radioactive iodine therapy.</td>
</tr>
</tbody>
</table>
Cinryze

Products Affected
- CINRYZE

<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 indication not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Lab values (C1-INH protein, serum C4)</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 allergist/immunologist or a provider who specializes in the treatment of hereditary angioedema or related disorders.</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>Hereditary Angioedema (HAE) (type I or type II) has been confirmed by low levels of functional C1-INH protein (less than 50% of normal) at baseline and lower than normal serum C4 levels at baseline. Must also meet the requirements of the non-preferred criteria.</td>
</tr>
</tbody>
</table>
Cometriq

Products Affected
• COMETRIQ

<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 worded as NSCLC with RET gene Rearrangements.</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 3 years</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Copiktra

## Products Affected
- COPIKTRA

<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 indication not otherwise excluded. Plus patients already started on Copiktra 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>3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>CLL/Follicular Lymphoma/SLL-approve if the patient has tried two prior therapies</td>
</tr>
</tbody>
</table>
# Corlanor

## Products Affected
- CORLANOR

<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Previous use of a Beta-blocker, LVEF, sinus rhythm, and resting HR</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>Prior Authorization will be approved for 12 months</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>HF in pts not currently receiving Corlanor - must all of the following: have LVEF of less than or equal 35 percent, have sinus rhythm and a resting HR of greater than or equal to 70 BPM, AND tried or is currently receiving a Beta-blocker for HF (e.g., metoprolol succinate sustained-release, carvedilol, bisoprolol, carvedilol ER) unless the patient has a contraindication to the use of beta blocker therapy (e.g., bronchospastic disease such as COPD and asthma, severe hypotension or bradycardia). HF in pts currently receiving Corlanor - had a LVEF of less than or equal to 35 percent prior to initiation of Corlanor therapy AND has tried or is currently receiving a Beta-blocker for HF unless the patient has a contraindication to the use of beta blocker therapy.</td>
</tr>
</tbody>
</table>
# Cotelllic

## Products Affected
- COTELLIC

<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 indication not otherwise excluded. Plus patients using Cotelllic 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>Melanoma initial - must have BRAF V600 mutation</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 for 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Melanoma, Unresectable or Metastatic: The patient has a BRAF V600 mutation AND Cotelllic is being prescribed in combination with Zelboraf (vemurafenib tablets).</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 indication 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 an endocrinologist or nephrologist</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Approval 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.</td>
</tr>
</tbody>
</table>
## Daraprim

### Products Affected
- DARAPRIM

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Medication history, patient's immune status</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Toxoplasma gondii Encephalitis, Cystoisosporiasis, PCP, Chronic Maintenance and Prophylaxis (Primary)-prescribed by or in consultation with an infectious diseases specialist. Toxoplasmosis Treatment-prescribed by or in consultation with an infectious diseases specialist, a maternal-fetal medicine specialist, or an ophthalmologist.</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>Other Criteria</td>
<td>Malaria Prophylaxis, approve if the patient has tried at least two other antimalarials (eg, atovaquone-proguanil, chloroquine phosphate,hydroxychloroquine sulfate, doxycycline, mefloquine, and primaquine). Malaria Treatment, approve if the patient has tried at least two other antimalarials (eg, Coartem [artemether-lumefantrine tablets], quinine sulfate or quinidine gluconate in combination with doxycycline, tetracycline, or clindamycin, quinine sulfate in combination with primaquine and either doxycycline or tetracycline, or the following medications as monotherapy or in combination with primaquine: atovaquone-proguanil, mefloquine, chloroquine phosphate, and hydroxychloroquine). Toxoplasma gondii Encephalitis, Chronic Maintenance, approve if the patient is immunosuppressed. Toxoplasma gondii Encephalitis Prophylaxis(Primary), approve if the patient is immunosuppressed and the patient has tried one other recommended therapy, unless contraindicated (eg, trimethoprim-sulfamethoxazole [TMP-SMX], atovaquone). Cystoisosporiasis pt is immunosuppressed AND has tried 1 other recommended therapy unless contraindicated (e.g., trimethoprim-sulfamethoxazole [TMP-SMX], ciprofloxacin). PCP patient is immunosuppressed AND B)The patient has tried one other recommended therapy, unless contraindicated (e.g., trimethoprim-sulfamethoxazole [TMP-SMX], dapsone, atovaquone, aerosolized pentamidine).</td>
</tr>
</tbody>
</table>
# Daurismo

## Products Affected
- DAURISMO

<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 indication not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, medications that will be used in combination, comorbidities</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>3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>AML - approve if Daurismo will be used in combination with cytarabine AND the patient is greater than or equal to 75 years old OR the patient has comorbidities that preclude the use of intensive induction chemotherapy according to the prescribing physician.</td>
</tr>
</tbody>
</table>
**DUPIXENT**

**Products Affected**
- DUPIXENT SUBCUTANEOUS SYRINGE
  300 MG/2 ML

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, prescriber specialty, other medications tried and length of trials</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Asthma/AD-12 years of age and older. Chronic Rhinosinusitis-18 and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Asthma-Prescribed by or in consultation with a an allergist, immunologist, pulmonologist. AD-prescribed by or in consultation with allergist, immunologist or dermatologist. Rhinosinusitis-prescribed by or in consultation with an allergist, immunologist or otolaryngologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Asthma/Rhinosinusitis initial-6 months, AD-Initial-16 weeks, Continuation-1 year</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
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<td>-------------</td>
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</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Atopic Dermatitis-Initial Therapy- Patient meets both of the following criteria: a. Patient has used at least one medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroid OR patient has atopic dermatitis affecting ONLY the face, eyes/eyelids, skin folds, and/or genitalia and has tried tacrolimus ointment, AND b. Inadequate efficacy was demonstrated with these previously tried topical prescription therapies, according to the prescribing physician. Continuation-Approve if the patient has responded to Dupixent therapy as determined by the prescribing physician (e.g., marked improvements erythema, induration/papulation/edema, excoriations, and lichenification, reduced pruritus, decreased requirement for other topical or systemic therapies, reduced body surface area (BSA) affected with atopic dermatitis, or other responses observed). Asthma-approve for add-on maintenance treatment in patients with moderate-to-severe asthma with an eosinophilic phenotype or with oral corticosteroid dependent asthma. Chronic rhinosinusitis with Nasal Polyposis-Initial-patient is currently receiving therapy with an intranasal corticosteroid AND is experiencing significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea, or reduction/loss of smell according to the prescriber AND meets ONE of the following (a or b): a) Patient has received treatment with a systemic corticosteroid within the previous 2 years or has a contraindication to systemic corticosteroid therapy OR b) Patient has had prior surgery for nasal polyps. Continuation-approve if the patient continues to receive therapy with an intranasal corticosteroid AND patient has responded to Dupixent therapy as determined by the prescriber.</td>
</tr>
</tbody>
</table>
# Elelyso

## Products Affected

- **ELELYSO**

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<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 indication 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>Authorization will be for 1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Emgality

### Products Affected
- EMGALITY PEN
- EMGALITY SYRINGE

<table>
<thead>
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<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indication 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, number of migraine headaches per month, prior therapies tried</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></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>Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND patient has tried at least two standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and has had inadequate responses to those therapies or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.</td>
</tr>
</tbody>
</table>
Enbrel

Products Affected
• ENBREL SUBCUTANEOUS RECON SOLN
• ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML)
• ENBREL SURECLICK

<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 patient already started on etanercept for a covered use. Graft versus host disease (GVHD). Behcet's disease. Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, mucous membrane pemphigoid [cicatricial pemphigoid]) (AMBD). Uveitis.</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 and other medications tried for the diagnosis provided.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Rheumatoid arthritis (RA), Psoriatic arthritis (PA), and Ankylosing spondylitis (AS), patients 18 years of age and older. Plaque psoriasis (PP), patients 4 years of age and older. Polyarticular Juvenile Idiopathic Arthritis (JIA)/ Juvenile Rheumatoid Arthritis (JRA) in patients 2 years of age and older. All other conditions, patients 18 years of age or older.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>RA/AS/JIA/JRA, prescribed by or in consult with rheumatologist. PA, prescribed by or in consultation with rheumatologist or dermatologist. PP/Cic Pemphigoid AMBD, prescribed by or in consult with a dermatologist. GVHD, prescribed by or in consult with an oncologist, hematologist, or physician affiliated with a transplant center. Behcets disease, prescribed by or in consult with a rheumatologist, dermatologist, ophthalmologist, gastroenterologist, or neurologist.</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>For RA, the patient must have had a trial with a conventional DMARD regimen (e.g., methotrexate, hydroxychloroquine, sulfasalazine, and leflunomide) including concurrent use of two or three of the conventional DMARDs for 3 months unless the patient experienced intolerance. For JIA/JRA, tried another agent (e.g., MTX, sulfasalazine, leflunomide, NSAID) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if the patient has absolute contraindication to MTX, sulfasalazine, or leflunomide or if the patient has aggressive disease. For PP, the patient has tried a systemic therapy (e.g., MTX, CSA, acitretin) for 3 months unless the patient experienced intolerance or PUVA for 3 months. For PA, the patient must have had a trial with a conventional DMARD (e.g., methotrexate, sulfasalazine, and leflunomide) for at least 3 months unless the patient experienced intolerance or has severe disease activity. For AS, must have active disease despite treatment with one or more NSAIDs. For GVHD, has tried or currently is receiving one conventional GVHD treatment (high-dose SC, CSA, tacrolimus, MM, thalidomide, antithymocyte globulin, etc.). For Behcet’s, have not responded to at least one conventional treatment (e.g., CS, immunosuppressant, interferon alfa, MM, etc). For Cic Pemp AMBD, tried 2 conventional treatments (e.g., systemic corticosteroids, azathioprine, cyclophosphamide, dapsone, MTX, cyclosporine, mycophenolate mofetil). For continuation of therapy for all conditions, prescriber attests the patient has had a response to treatment.</td>
</tr>
</tbody>
</table>
## Endari

### Products Affected
- ENDARI

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>Sickle Cell Disease</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>5 years of age or older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>prescribed by, or in consultation with, a physician who specializes in sickle cell disease (e.g., a hematologist)</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Epogen/Procrit

### Products Affected
- PROCRIT

<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 worded as anemia associated with chronic renal failure (CRF), including patients on dialysis and not on dialysis, and worded as anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia. Anemia due to myelodysplastic syndrome (MDS). Plus anemia in patients with HIV(with or without zidovudine). Patients using for perisurgical adjuvant therapy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion Criteria</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Required Medical Information</th>
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<table>
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<tr>
<th>Age Restrictions</th>
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<table>
<thead>
<tr>
<th>Prescriber Restrictions</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Coverage Duration</th>
<th>CKD and MDS - Authorization will be for 6 months, Perisurgical - 1 month, Other - 4 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Confirmation of adequate iron stores at initiation of therapy (eg, prescribing information recommends supplemental iron therapy when serum ferritin is less than 100 mcg/L or when serum transferrin saturation is less than 20%). CRF anemia in patients on and not on dialysis. Hemoglobin (Hb) of less than 10.0 g/dL for adults or less than or equal to 11 g/dL for children to start. Hb less than or equal to 11.5 g/dL for adults or 12 g/dL or less for children if currently on epoetin alfa or Aranesp. Anemia w/myelosuppressive chemotx. pt must be currently receiving myelosuppressive chemo and Hb 10.0 g/dL or less to start. Hb less than or equal to 12.0 g/dL if currently on epoetin alfa or Aranesp. MDS, approve if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start. Currently receiving Aranesp or EA, approve if Hb is 12.0 g/dL or less. Anemia in HIV (with or without zidovudine), Hb is 10.0 g/dL or less or endogenous erythropoetin levels are 500 munits/mL or less at tx start. Currently on EA approve if Hb is 12.0 g/dL or less. Perisurgical adjuvant therapy, patient is undergoing hip or knee surgery, has Hgb between 10 and 13 g/dL, is not a candidate for autologous blood transfusion.</td>
</tr>
</tbody>
</table>
## Erivedge

### Products Affected
- ERIVEDGE

<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>BCC (La or Met) - must not have had disease progression while on Odomzo.</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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Basal Cell Carcinoma (BCC), Locally Advanced - Approve if the patients meets ONE of the following conditions: The patient's basal cell carcinoma has recurred following surgery or radiation therapy OR The patient is not a candidate for surgery AND the patient is not a candidate for radiation therapy, according to the prescribing physician</td>
</tr>
</tbody>
</table>
## Erleada

**Products Affected**
- ERLEADA

<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 indication 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>Authorization will be for 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Esbriet

## Products Affected
- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG

<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>Concomitant use with Ofev.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>The patient is aged greater than or equal to 40 years old.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>The agent has been prescribed by, or in consultation with, a pulmonologist.</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>Idiopathic Pulmonary Fibrosis - At baseline (before therapy initiation), patients have an FVC greater than or equal to 50% of the predicted value AND The diagnosis of IPF is confirmed by one of the following (i or ii) i. Findings on high-resolution computed tomography (HRCT) indicates usual interstitial pneumonia (UIP), OR ii.A surgical lung biopsy demonstrates usual interstitial pneumonia (UIP).</td>
</tr>
</tbody>
</table>
# Exjade

**Products Affected**

- deferasirox oral tablet, dispersible

<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>Serum ferritin level</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 hematologist</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>Transfusion-related chronic iron overload, initial therapy - approve if the patient is receiving blood transfusions at regular intervals for various conditions (eg, thalassemia syndromes, myelodysplastic syndrome, chronic anemia, sickle cell disease) AND prior to starting therapy, the serum ferritin level is greater than 1,000 mcg/L. Non-transfusion-dependent thalassemia syndromes chronic iron overload, initial therapy - approve if prior to starting therapy the serum ferritin level is greater than 300 mcg/L. Continuation therapy - approve is the patient is benefiting from therapy as confirmed by the prescribing physician.</td>
</tr>
</tbody>
</table>
## Fabrazyme

**Products Affected**
- FABRAZYME

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
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</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>
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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 1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Farydak

**Products Affected**
- FARYDAK

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</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></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></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization is for 12 months</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>MM - must be used in combination with Velcade and dexamethasone AND previously tried Velcade and one immunomodulatory drug (i.e., Thalomid, Revlimid, or Pomalyt).</td>
</tr>
</tbody>
</table>
# Fasenra

## Products Affected
- FASENRA
- FASENRA PEN

<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 indication 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 will be for 6 months initial, 12 months continuation.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Other Criteria</td>
<td><strong>Initial</strong> - must have peripheral blood eosinophil count of greater than or equal to 150 cells per microliter within the previous 6 weeks or prior to treatment with any IL-5 antagonist monoclonal antibody AND meet both of the following criteria: 1) Patient has received at least 3 consecutive months of combination therapy with an inhaled corticosteroid AND one of the following: inhaled LABA, inhaled long-acting muscarinic antagonist, Leukotriene receptor antagonist, zafirlukast, or Theophylline, AND 2) Patient's asthma is uncontrolled or was uncontrolled prior to starting any IL-antagonist therapy as defined by ONE of the following: a) patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, OR b) patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year, OR c) patient has a FEV1 less than 80 percent predicted, OR d) Patient has an FEV1/FVC less than 0.80, OR e) Patient's asthma worsens upon tapering of oral corticosteroid therapy. <strong>Continuation</strong> - The patient has already received 6 months of therapy with Fasenra AND has responded to Fasenra therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations, decreased asthma symptoms, decreased hospitalizations, emergency department (ED)/urgent care, or physician visits due to asthma, decreased requirement for oral corticosteroid therapy) AND patient continues to receive therapy with an inhaled corticosteroid.</td>
</tr>
</tbody>
</table>
# Ferriprox

## Products Affected
- FERRIPROX ORAL TABLET

<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Serum ferritin level</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 hematologist</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>Initial therapy - approve if prior to starting therapy the serum ferritin level was greater than 2,500 mcg/L. Continuation therapy - approve is the patient is benefiting from therapy as confirmed by the prescribing physician.</td>
</tr>
</tbody>
</table>
## Firazyr

### Products Affected
- FIRAZYR

<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Lab values (C1-INH protein, serum C4)</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 allergist/immunologist or a physician that specializes in the treatment of Hereditary Angioedema (HAE) or related disorder</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>Hereditary Angioedema (HAE) (type I or type II) has been confirmed by low levels of functional C1-INH protein (less than 50% of normal) at baseline and by lower than normal serum C4 levels at baseline. Must also meet the requirements of the non-preferred criteria.</td>
</tr>
</tbody>
</table>
## Gilotrif

### Products Affected
- GILOTIF

<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis of metastatic Non-Small Cell Lung Cancer (NSCLC)</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>Patient must have epidermal growth factor receptor (EGFR) exon 19 deletion as detected by a Food and Drug Administration (FDA)-approved test OR the patient does not have exon 21 (L858R) substitution as detected by an FDA-approved test.</td>
</tr>
</tbody>
</table>
# Gleevec/imatinib

## Products Affected
- imatinib oral tablet 100 mg, 400 mg

<table>
<thead>
<tr>
<th><strong>PA Criteria</strong></th>
<th><strong>Criteria Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA approved indications not otherwise excluded. Plus chordoma, advanced or unresectable fibromatosis (desmoid tumors), cKit positive advanced/recurrent or metastatic melanoma, and pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor, Graft Versus Host Disease (Chronic) and patients continuing treatment for an approved use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.</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 3 years. GVHD approve for 1 year.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For ALL/CML, new patient must have Ph-positive for approval of imatinib. MDS/MPD condition is associated with platelet derived growth factor receptor gene rearrangements. GVHD approve if patient has tried one conventional systemic treatment for graft versus host disease (e.g., corticosteroids [methylprednisolone, prednisone], cyclosporine, tacrolimus, mycophenolate mofetil, Imbruvica® [ibrutinib capsules]).</td>
</tr>
</tbody>
</table>
# Glucagon-like Peptide-1 Agonists

**Products Affected**

- RYBELSUS

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</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></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></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></td>
</tr>
</tbody>
</table>
Glucose Test Strips and Meters

Products Affected

- FORA G20
- FREESTYLE FREEDOM LITE
- FREESTYLE INSULINX
- FREESTYLE INSULINX TEST STRIPS
- FREESTYLE LITE METER
- FREESTYLE LITE STRIPS
- FREESTYLE TEST
- GLUCOCARD EXPRESSION
- GLUCOCARD EXPRESSION KIT
- GLUCOCARD EXPRESSION STRIP
- GLUCOCARD SHINE METER
- GLUCOCARD SHINE METER KIT
- GLUCOCARD SHINE TEST STRIPS
- GLUCOCARD SHINE XL METER
- ONETOUCH ULTRA BLUE TEST STRIP
- ONETOUCH ULTRA2 METER
- ONETOUCH ULTRAMINI
- ONETOUCH VERIO
- ONETOUCH VERIO FLEX
- ONETOUCH VERIO IQ METER
- ONETOUCH VERIO SYSTEM
- PRECISION XTRA KETONE-GLUCOSE
- PRECISION XTRA MONITOR
- PRECISION XTRA TEST
- PRODIGY NO CODING
- PRODIGY POCKET METER
- PRODIGY VOICE GLUCOSE METER
- TRUE METRIX AIR GLUCOSE METER
- TRUE METRIX GLUCOSE METER
- TRUE METRIX GLUCOSE TEST STRIP
- WAVESENSE PRESTO

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Previous supplies tried and failed.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approval duration of 1 year</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Required to try two different preferred Contour or Accu-Chek meters and tests strips or have a clinical reason why these cannot be tried. Approve if the patient requires a specific brand meter and test strip due to insulin pump requirements or due to vision impairment.</td>
</tr>
</tbody>
</table>
# Growth Hormones

## Products Affected
- GENOTROPIN
- GENOTROPIN MINIQUICK
- HUMATROPE
- NORDITROPIN FLEXPRO
- NUTROPIN AQ NUSPIN
- OMNITROPE
- SAIZEN
- SAIZEN SAIZENPREP
- SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG
- ZOMACTON
- ZORBTIVE

## PA Criteria
### Covered Uses

### Exclusion Criteria
Use in the management of acute critical illness due to complications of surgery, trauma, or with acute respiratory failure, as antiaging therapy, to improve functional status in elderly, somatopause, enhancement of athletic ability, bone marrow transplant (BMT) without total body irradiation, bony dysplasias, burn injury, cardiac transplantation, central precocious puberty, chronic fatigue syndrome, congenital adrenal hyperplasia, constitutional delay of growth and puberty, corticosteroid-induced short stature including a variety of chronic glucocorticoid-dependent conditions, such as asthma, juvenile rheumatoid arthritis, after renal, heart, liver, or BMT, Crohn's disease, cystic fibrosis, dilated cardiomyopathy/heart failure, end-stage renal disease in adults undergoing hemodialysis, Down's syndrome, familial dysautonomia, fibromyalgia, HIV-infected patients with alterations in body fat distribution, infertility, kidney transplant patients (children) with a functional renal allograft, liver transplantation, multiple system atrophy, myelomeningocele, obesity, osteogenesis imperfecta, osteoporosis (postmenopausal, idiopathic in men, glucocorticoid-induced), thalassemia, and X-linked hypophosphatemic rickets (familial hypophosphatemia, hypophosphatemic rickets).

## Required Medical Information
<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Child/adolesc w/GH DF (initial tx), adolescent is less than or equal to 18 years of age. TS, children. SHOX/CRI/NS, children/adolescents. HIV infection w/wasting or cachexia, less than or equal to 18 years of age. SBS/HIV cachexia/wasting, adults.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>For adults, the endocrinologist must certify that the somatropin is not being prescribed for anti-aging therapy or to enhance athletic ability. All conditions - prescribed by or in consultation with an endocrinologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>GH DF 12 mos. SBS 4-8wks/yr. Non-GH DF ISS 6 mos. HIV wast/cach 24 wks.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>-------------</td>
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</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Child/adol GH DF initial tx, documented GH stimulation test w/GH response less than 10 ng/mL AND base Ht less than the 10th pct for gender/age + pretx Ht growth rate (GR) child less than 3 yrs of less than 7 cm/yr and child greater than or equal to 3 yrs of less than 4 cm/yr OR child/adol less than 18 yrs of age GR less than the 10th pct for age/gender based on min 6 mo data. Child w/brain radiation does not have to meet base Ht criteria above but growth rate criteria does apply. Congenital hypopituitarism does not have to meet Ht or growth rate crit. Child w/hypophysectomy, approve. Child/adol GH DF cont tx, GR increased by 4 cm/yr or more in most recent yr (MRY) + epiphyses open (between 12 and 18 yrs), both crit exclude adol w/hypopituit. Review GR annually. Adoles/yn adult w/completed linear growth (GR less than 2 cm/yr), review for adult GH DF. Greater than 18 yrs, GR increased by 4 cm/yr or more in MRY AND epiphyses open, auth not allowed if midparental ht attained. ISS child w/open epiphyses, 6 mo trial if base Ht less than 5th pct + pretx GR child greater than or equal to 7 yrs of less than 4 cm/yr and child 3 or more yrs of less than 4 cm/yr OR child any age GR less than the 10th pct for age/gender based on min 6 mo of data and has condition which GH effective + endocrinol certifies via bone-age x-ray, + the pt doesn’t have constitutional delay of growth and puberty (CDGP). Auth after initial tx based on adequate clinical response (annualized GR doubles). Cont tx, at least 7 yrs and received somatropin on 6 mo trial, if GR has doubled in comparison to previous yr. At least 7 and less than 12 yrs, GR increased by 4 cm/yr or more in MRY. At least 12 and less than or equal to 18 yrs, GR increased by 4 cm/yr or more in MRY AND epiphyses open). Greater than 18 yrs, GR increased by 4 cm/yr or more in MRY, + epiphyses open auth not allowed if midparental ht attained. Adult GH DF or PW/trans adole, eval by endocrinol (start and annually). NS/SHOX/child PW, eval by an endocrinol, CKD, eval by an endocrin or nephrologist. Non-preferred drugs are also required to meet the non-preferred drug criteria.</td>
</tr>
</tbody>
</table>
# Hemlibra

**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>Prescriber specialty, patient medical history.</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>Prescribed by or in consultation with a hemophilia specialist</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>Patient is using Hemlibra for routine prophylaxis</td>
</tr>
</tbody>
</table>
## Hepatitis C Agents

### Products Affected

- DAKLINZA
- EPCLUSA
- HARVONI ORAL TABLET 90-400 MG
- ledipasvir-sofosbuvir
- MAVYRET
- sofosbuvir-velpatasvir
- SOVALDI ORAL TABLET 400 MG
- TECHNIVIE
- VIEKIRA PAK
- VOSEVI
- ZEPATIER

<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>Consistent with MN DHS criteria.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Consistent with MN DHS criteria.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Consistent with MN DHS criteria.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Consistent with MN DHS criteria.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Consistent with AASLD guidelines</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Consistent with MN DHS criteria.</td>
</tr>
</tbody>
</table>
# Humira

## Products Affected
- HUMIRA
- HUMIRA PEDIATRIC CROHNS STARTER
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS STARTER
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA(CF)
- HUMIRA(CF) PEDIATRIC CROHNS STARTER
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML

## PA Criteria | Criteria Details
---|---
**Covered Uses** | All FDA-approved indications not otherwise excluded plus patients already started on adalimumab for a covered use. Other covered uses: Behcet's disease, pyoderma gangrenosum, undifferentiated spondylarthritides (undiifferentiated arthritis), sarcoidosis, scleritis or sterile corneal ulceration.

**Exclusion Criteria** | 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.

**Required Medical Information** | Diagnosis and other medications tried for the diagnosis provided.

**Age Restrictions** | Rheumatoid arthritis (RA), Psoriatic arthritis (PA), Ankylosing spondylitis (AS), Ulcerative colitis (UC), and Plaque psoriasis (PP), patients 18 years of age and older. Polyarticular Juvenile Idiopathic Arthritis (JIA) and Uveitis in patients aged 2 years and older. Hidradenitis suppurativa for patients 12 years of age and older. Crohn's disease (CD), patients 6 years of age and older. All other conditions, patients 18 years of age and older.

**Prescriber Restrictions** | RA/JIA/JRA/AS, prescribed by or in consultation with rheumatologist. PA, prescribed by or in consultation with a rheumatologist or dermatologist. PP, prescribed by or in consultation with a dermatologist. UC/CD, prescribed by or in consultation with a gastroenterologist.

**Coverage Duration** | Authorization will be for 12 months
<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For RA, the patient must have had a trial with a conventional DMARD regimen (e.g., methotrexate, hydroxychloroquine, sulfasalazine, and leflunomide) including concurrent use of two or three of the conventional DMARDs for 3 months unless the patient experienced intolerance. For JIA/JRA, tried another agent (e.g., MTX, sulfasalazine, leflunomide, NSAID) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if the patient has absolute contraindication to MTX, sulfasalazine, or leflunomide or if the patient has aggressive disease. For PP, the patient has tried a systemic therapy (e.g., MTX, CSA, acitretin) for 3 months unless the patient experienced intolerance or PUVA for 3 months. For PA, the patient must have had a trial with a conventional DMARD (e.g., methotrexate, sulfasalazine, and leflunomide) for at least 3 months unless the patient experienced intolerance or has severe disease activity. For AS, must have active disease despite treatment with one or more NSAIDs. For CD, the patient has failed corticosteroid (CS) or if CS contraindicated or if currently on CS and unable to taper off or if the patient has tried one other agent for CD for 3 months (e.g., azathioprine, 6-MP, MTX) or the patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas or the patient has had ileocolonic resection. For UC, the patient has tried a systemic therapy (e.g., 6-mercaptopurine, azathioprine, CSA, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone) for 3 months or was intolerant to one of these agents, or the patient has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine (Rowasa) enema. For continuation of therapy for all conditions, prescriber attests the patient has had a response to treatment.</td>
</tr>
</tbody>
</table>
# Ibrance

## Products Affected
- IBRANCE ORAL CAPSULE

<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 breast cancer in men and liposarcoma.</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></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization for 12 months</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Breast cancer in women - approve in advanced (metastatic) ER positive disease and HER2-negative breast cancer. Ibrance will be used in combination with letrozole as initial endocrine-based therapy in postmenopausal women OR in combination with Faslodex in women with disease progression following endocrine therapy. Breast Cancer in men - approve in advanced (metastatic) ER positive disease and HER2-negative breast cancer. The patient is receiving a leutinizing hormone-releasing hormone (LHRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex (goserelin]) AND Ibrance will be used as first-line endocrine therapy in combination with anastrozole, exemestane, or letrozole. Liposarcoma - approve is the patient has well-differentiated/dedifferentiated liposarcoma.</td>
</tr>
</tbody>
</table>
# Iclusig

**Products Affected**
- ICLUSIG ORAL TABLET 15 MG, 45 MG

<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 Iclusig 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></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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For Chronic Myeloid Leukemia (CML) That is Philadelphia Chromosome Positive. Approve if the patient meets ONE of the following criteria: the patient is T315I-positive, OR the patient has tried two other tyrosine kinase inhibitors indicated for use in Philadelphia chromosome positive CML (e.g., Gleevec® [imatinib tablets], Sprycel® [dasatinib tablets], Tasigna® [nilotinib capsules]). For Acute Lymphoblastic Leukemia (ALL) That is Philadelphia Chromosome Positive (Ph+). Approve if the patient meets ONE of the following criteria: the patient is T315I-positive, OR the patient has tried two other tyrosine kinase inhibitors that are used for Philadelphia chromosome positive ALL (e.g., Gleevec® [imatinib tablets], Sprycel® [dasatinib tablets]).</td>
</tr>
</tbody>
</table>
# Idhifa

## Products Affected

- IDHIFA

## 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 FDA-approved indications not otherwise excluded. Plus patients started on Idhifa 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>IDH2-mutation status</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>18 years old and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td></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>AML - approve if relapsed or refractory AND the patient is IDH2-mutation status positive as detected by an approved test.</td>
</tr>
</tbody>
</table>
# Imbruvica

## Products Affected
- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG

<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. Other Acceptable Uses: Relapsed or refractory CNS lymphoma, Diffuse Large B-Cell Lymphoma (e.g., follicular lymphoma, gastric MALT lymphoma, nongastric MALT lymphoma, primary DLBCL of the central nervous system [CNS]), Relapsed or refractory Hairy Cell Leukemia.</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 3 years, GVHD authorization will be for 1 year.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Marginal Zone Lymphoma pt has tried Rituxan (rituximab for IV infusion) or according to the prescribing physician, Rituxan is contraindicated for use in this patient. GVHD the patient has tried one conventional systemic treatment for graft versus host disease (e.g., corticosteroids [methylprednisolone, prednisone], cyclosporine, tacrolimus, mycophenolate mofetil, imatinib). For Diffuse Large B-Cell Lymphoma approve if according to the prescribing physician, the patient is using as a second-line or subsequent therapy.</td>
</tr>
</tbody>
</table>
## Inlyta

### Products Affected
- INLYTA

<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, Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma.</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></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>Advanced renal cell carcinoma, approve. Differentiated thyroid cancer, approve if patient is refractory to radioactive iodine therapy.</td>
</tr>
</tbody>
</table>
# Iressa

**Products Affected**
- IRESSA

<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></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></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>Metastatic NSCLC - The patient has epidermal growth factor receptor (EGFR) exon 19 deletions OR has exon 21 (L858R) substitution mutations as detected by an FDA-approved test.</td>
</tr>
</tbody>
</table>
## Jadenu

### Products Affected
- deferasirox oral tablet 360 mg, 90 mg

<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Serum ferritin level</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 hematologist</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>Transfusion-related chronic iron overload, initial therapy - approve if the patient is receiving blood transfusions at regular intervals for various conditions (eg, thalassemia syndromes, myelodysplastic syndrome, chronic anemia, sickle cell disease) AND prior to starting therapy, the serum ferritin level is greater than 1,000 mcg/L. Non-transfusion dependent thalassemia syndromes chronic iron overload, initial therapy - approve if prior to starting therapy the serum ferritin level is greater than 300 mcg/L. Continuation therapy - approve is the patient is benefiting from therapy as confirmed by the prescribing physician.</td>
</tr>
</tbody>
</table>
### Jakafi

**Products Affected**
- JAKAFI

<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></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></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>For polycythemia vera patients must have tried hydroxyurea.</td>
</tr>
</tbody>
</table>
Jynarque

Products Affected
• JYNARQUE

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Patient is currently receiving Samsca (tolvaptan tablets). Patients with Stage 5 CKD</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis, renal function</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>18 years and older</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a nephrologist</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approval for 1 year</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Approve if the patient has rapidly-progressing autosomal dominant polycystic kidney disease (ADPKD) (e.g., reduced or declining renal function, high or increasing total kidney volume [height adjusted]), according to the prescriber.</td>
</tr>
</tbody>
</table>
Kalydeco

Products Affected

• KALYDECO ORAL GRANULES IN PACKET 50 MG, 75 MG
• KALYDECO ORAL TABLET

<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>Combination use with Orkambi or Symdeko</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>12 months of age or older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 3 years.</td>
</tr>
</tbody>
</table>
Kisqali

Products Affected
- KISQALI
- KISQALI FEMARA CO-PACK

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved 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></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approval for 3 years</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Breast cancer - approve advanced or metastatic hormone receptor positive (HR+)</td>
</tr>
<tr>
<td></td>
<td>[i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive</td>
</tr>
<tr>
<td></td>
<td>(PR+)] disease, and HER2-negative breast cancer when the pt meets ONE of the</td>
</tr>
<tr>
<td></td>
<td>following 1. Pt is postmenopausal and Kisqali will be used as first line</td>
</tr>
<tr>
<td></td>
<td>endocrine therapy in combination with anastrozole, exemestane, or letrozole</td>
</tr>
<tr>
<td></td>
<td>2. Pt is premenopausal or perimenopausal and is receiving ovarian suppression/</td>
</tr>
<tr>
<td></td>
<td>ablation with LHRH agonist, surgical bilateral oophorectomy, or ovarian</td>
</tr>
<tr>
<td></td>
<td>irradiation AND Kisqali will be used as first line endocrine therapy in</td>
</tr>
<tr>
<td></td>
<td>combination with anastrozole, exemestane, or letrozole 3. Pt is a man (a man</td>
</tr>
<tr>
<td></td>
<td>is defined as an individual with the biological traits of a man, regardless of</td>
</tr>
<tr>
<td></td>
<td>the individual's gender identity or gender expression) who is receiving LHRH</td>
</tr>
<tr>
<td></td>
<td>agonist AND Kisqali with be used as first line endocrine therapy in combination</td>
</tr>
<tr>
<td></td>
<td>with anastrozole, exemestane or letrozole.</td>
</tr>
</tbody>
</table>
# Lenvima

## Products Affected
- LENVIMA

<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. Other approved uses: Medullary thyroid carcinoma</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></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization for 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>DTC - must be refractory to radioactive iodine treatment. RCC - The patient meets the following criteria: Patient has RCC with predominant clear-cell histology AND Patient has tried one antiangiogenic therapy (e.g., Inlyta® [axitinib tablets], Votrient® [pazopanib tablets], Sutent® [sunitinib capsules], or Cabometyx) AND Lenvima is used in combination with Afinitor® (everolimus tablets)/Afinitor® Disperz™ (everolimus tablets for oral suspension) therapy OR The patient meets the following criteria: Patient has RCC with non-clear cell histology AND Lenvima is used in combination with Afinitor® (everolimus tablets)/Afinitor® Disperz™ (everolimus tablets for oral suspension) therapy. For MTC, approve if patient has tried Caprelsa or Cometriq</td>
</tr>
</tbody>
</table>
Letairis Tracleer

Products Affected
• LETAIRIS

<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>The patient has a diagnosis of PAH (WHO Group 1)</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>For Pulmonary Arterial Hypertension (PAH) or Chronic Thromboembolic Pulmonary Hypertension (CTEPH) must be prescribed by or in consultation with a cardiologist or a pulmonologist</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>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 PAH patient must have had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). For Digital Ulcers/Systemic Sclerosis approve if patient has tried two other therapies for this condition such as calcium channel blockers (CCBs) [e.g., amlodipine, felodipine, nifedipine], alpha-adrenergic blockers (e.g., prazosin), nitroglycerin, phosphodiesterase type 5 (PDE5) inhibitors (e.g., sildenafil tablets, Levitra® [vardenafil tablets]), or angiotensin converting enzyme (ACE) inhibitors OR the patient has tried one vasodilator/prostanoid therapy (e.g., epoprostenol injection, alprostadil injection). For Chronic Thromboembolic Pulmonary Hypertension (CTEPH) approve if he patient meets ONE of the following: The patient has tried Adempas OR The patient has a specific contraindication to use of Adempas according to the prescribing physician (e.g., the patient is receiving nitrates or nitric oxide donors, the patient is receiving a phosphodiesterase inhibitor [e.g., Revatio, Adcirca], the patient is hypotensive or is at risk for hypotension) OR The patient is currently receiving Tracleer for CTEPH.</td>
</tr>
</tbody>
</table>
# Long Acting Opioids

## Products Affected

- ARYMO ER
- BELBUCA
- Buprenorphine transdermal patch weekly 10 mcg/hour, 15 mcg/hour, 20 mcg/hour, 5 mcg/hour
- DURAGESIC
- EMBEDA ORAL CAPSULE, ORAL ONLY, EXT.REL PELL
- EXALGO ER
- Fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hr, 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr
- Hydromorphone oral tablet extended release 24 hr
- HYSINGLA ER
- MORPHABOND ER
- morphine oral capsule, er multiphase 24 hr
- morphine oral capsule, extend.release pellets
- morphine oral tablet 15 mg
- morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg
- MS CONTIN
- NUCYNTA
- NUCYNTA ER
- OPANA ER ORAL TABLET, ORAL ONLY, EXT.REL.12 HR
- OXYCODONE ORAL TABLET, ORAL ONLY, EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG
- OXYCONTIN ORAL TABLET, ORAL ONLY, EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG
- oxymorphone oral tablet extended release 12 hr
- XTAMPZA ER
- ZOHYDRO ER ORAL CAPSULE, ORAL ONLY, ER 12HR

## PA Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded worded as pain severe enough to require daily, around-the-clock, long-term opioid treatment. Plus patients with a cancer or sickle cell diagnosis, patients in a hospice program/end-of-life care/palliative care.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Acute pain (pain which has been occurring for less than 3 months or is within the time of normal tissue healing).</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Authorization will be for 12 months</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>For pain severe enough to require daily, around-the-clock, long-term opioid treatment greater than 3 months or past the time of normal tissue healing (with no cancer or sickle cell diagnosis and not in hospice), approve if all of the following criteria are met: 1) patient is not opioid naive (except if a buprenorphine product is prescribed), AND 2) non-opioid therapies have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), unless unavailable in the state, AND 4) the prescribing physician has discussed risks (e.g., addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids require confirmation that the indication is intractable pain (i.e., FDA labeled use) prior to reviewing for quantity exception. Non-preferred drug are also required to meet the non-preferred drug criteria.</td>
</tr>
</tbody>
</table>
**Lonsurf**

**Products Affected**
- LONSURF

<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 currently taking Lonsurf 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></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 is for 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>CRC - As per labeling, the patient has been previously treated with a fluoropyrimidine (e.g., capecitabine, 5-FU) AND oxaliplatin AND irinotecan AND if the tumor or metastases are wild-type KRAS and/or NRAS (that is, the tumors or metastases are KRAS and/or NRAS mutation negative) Erbitux or Vectibix has been tried.</td>
</tr>
</tbody>
</table>
# Lorbrena

## Products Affected
- LORBRENA

<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 Lorbrena 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, ALK status, 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>3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>NSCLC - Approve if the patient has ALK-positive metastatic NSCLC and meets one of the following:a) patient has disease progression on Xalkori (crizotinib capsules) and at least one other ALK inhibitor (e.g., Zykadia [ceritinib capsules], Alecensa [alectinib capsules], Alunbrig [brigatinib tablets]), or b) patient has disease progression on Alecensa (alectinib capsules) as the first ALK inhibitor therapy, or c) patient has disease progression on Zykadia (ceritinib capsules) as the first ALK inhibitor therapy.</td>
</tr>
</tbody>
</table>
# Lumizyme

**Products Affected**
- LUMIZYME

<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></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 1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Lupron (Long-Acting)

## Products Affected
- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)
- LUPRON DEPOT-PED
- LUPRON DEPOT-PED (3 MONTH)

## Covered Uses
All FDA-approved indications not otherwise excluded but specific to the following drugs as follows: Prostate cancer (Lupron Depot [7.5mg-1mo, 22.5mg-3mo, 30mg-4mo, 45mg-6mo] OR Eligard [7.5mg-1mo, 22.5mg-3mo, 30mg-4mo, 45mg-6mo]), Endometriosis (Lupron Depot [3.75mg, 11.25mg-3mo]), Uterine leiomyomata (Lupron Depot [3.75mg, 11.25mg-3mo]), Treatment of central precocious puberty (Lupron Depot Ped [11.25mg-1mo, 11.25mg-3mo, 15mg-1mo]). Ovarian cancer (Lupron Depot [7.5mg]). Breast cancer (Lupron Depot [3.75mg, 11.25-3mo]). Prophylaxis or treatment of uterine bleeding in premenopausal patient with hematologic malignancy or prior to bone marrow/stem cell transplantation (BMT/SCT) (Lupron Depot [7.5mg]).

## Exclusion Criteria

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
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</thead>
<tbody>
<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>For abnormal uterine bleeding, uterine leiomyomata, endometriosis - 6 months. All other Dx - 1 year</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Lynparza

### Products Affected
- LYNPARZA ORAL TABLET

<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 metastatic germline BRCA mutation-positive breast cancer and patients already started on Lynparza 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></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 3 years.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
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</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Ovarian Cancer - Treatment Initial Therapy Approve if the patient meets the following criteria: The patient has a germline BRCA-mutation as confirmed by an approved test AND The patient has progressed on three or more prior lines of chemotherapy. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer - Recurrence, Maintenance Therapy if the patient meets the following criteria: The patient has received at least two prior platinum-based chemotherapy regimens AND The patient has had a complete response or a partial response after platinum-based chemotherapy regimen AND Lynparza is requested for maintenance treatment. Breast Cancer. Approve if the patients meets the following criteria: The patient has metastatic, germline BRCA mutation-positive breast cancer AND The patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND The patient meets ONE of the following criteria: The patient has hormone receptor positive (HR+) [i.e., estrogen receptor positive {ER+} and/or progesterone receptor positive {PR+}] disease OR Patient has triple negative disease (i.e., ER-negative, PR-negative, and HER2-negative) AND The patient meets BOTH of the following criteria: The patient had received up to two (i.e., not more than two) previous chemotherapies for metastatic disease AND Patient had received prior treatment (e.g., neoadjuvant, adjuvant, treatment for metastatic disease) with an anthracycline (unless contraindicated) and a taxane (e.g., doxorubicin and cyclophosphamide followed by paclitaxel, docetaxel and cyclophosphamide, epirubicin and cyclophosphamide, single agent doxorubicin, single agent paclitaxel).</td>
</tr>
</tbody>
</table>
Makena

Products Affected

- hydroxyprogest(pf)(preg presv)
- hydroxyprogesterone cap(ppres)
- hydroxyprogesterone capr(bulk)
- hydroxyprogesterone caproate

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Preterm labor - Patients pregnant with multiple gestations (e.g., twins, triplets, or other multiples).</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>Preterm Labor - Medication being prescribed by (or with a documented consultation from) a Maternal Fetal Medicine specialist, or OBGYN specialty.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Preterm Labor - 21 weeks. All other indications - 12 months.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Preterm Labor - Patient is pregnant with a singleton pregnancy, AND Patient has a history of singleton spontaneous preterm birth (SPTB) prior to 37 weeks gestation, AND Treatment will begin in patients who are at least 16 weeks, 0 days of gestation, according to the prescribing physician or other prescriber.</td>
</tr>
</tbody>
</table>
# Megestrol

## Products Affected
- megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 800 mg/20 ml (20 ml)
- megestrol oral tablet

<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>Coverage is not provided for weight gain for cosmetic reasons</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 1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Mekinist

## Products Affected
- MEKINIST

<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 currently taking Mekinist for an approved use.</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></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>Initial Therapy: The patient has the BRAF V600 mutation AND The patient meets ONE of the following conditions: Mekinist will be used in combination with Tafinlar (dabrafenib tablets) OR Mekinist will be used as monotherapy in a patient who has not previously experienced disease progression on prior BRAF inhibitor treatment (e.g., Tafinlar or Zelboraf [vemurafenib tablets]).</td>
</tr>
</tbody>
</table>
## Mektovi

### Products Affected
- MEKTOVI

<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 Mektovi 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, BRAF V600 mutations</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>Approval duration of 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For unresectable or metastatic malignant melanoma with BRAF V600E or V600K mutation. Melanoma - Must prescribed in combination with Braftovi.</td>
</tr>
</tbody>
</table>
## Movantik

**Products Affected**
- MOVANTIK

<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></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></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>Opioid induced constipation (OIC): Previous trial and failure of polyethylene glycol.</td>
</tr>
</tbody>
</table>
## Multiple Sclerosis Agents

### Products Affected
- AUBAGIO
- AVONEX (WITH ALBUMIN)
- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- BETASERON
- COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML
- GILENYA ORAL CAPSULE 0.5 MG
- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML, 8.8 MCG/0.2 ML, 22 MCG/0.5 ML (6)
- REBIF TITRATION PACK

### PA Criteria

<table>
<thead>
<tr>
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</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>Diagnosis</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></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></td>
</tr>
</tbody>
</table>
# Myalept

**Products Affected**
- MYALEPT

<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></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>Prescribed by, or in consultation with, an endocrinologist or a geneticist physician specialist</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></td>
</tr>
</tbody>
</table>
Natpara

Products Affected
- NATPARA

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved 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></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with an endocrinologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Authorization will be for 3 years</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Chronic hypoparathyroidism - Before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician AND as per product labeling, patient cannot be well-controlled on calcium supplements and active forms of vitamin D alone. For continuation - The patient is responding to Natpara therapy (e.g., reduction in the patient's oral calcium dose, reduction in the patient's active vitamin D dose, maintenance of a stable albumin-corrected total serum calcium concentration), as determined by the prescriber.</td>
</tr>
</tbody>
</table>
Nerlynx

Products Affected
• NERLYNX

<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 started on Nerlynx for a Covered Use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Previous completion of a full year of adjuvant treatment for HER2 overexpression breast cancer with Perjeta.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, HER2 status, Herceptin treatment status</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>18 years or older</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>Breast Cancer (Women or Men) - Patient has early stage disease, AND patient has epidermal growth factor receptor 2 (HER2)-positive breast cancer, AND the patient meets ONE of the following: (i)The patient has completed 1 year of adjuvant therapy with Herceptin (trastuzumab intravenous injection), OR (ii) The patient has tried adjuvant therapy with Herceptin (trastuzumab intravenous injection) and could not tolerate 1 year of therapy, according to the prescribing physician.</td>
</tr>
</tbody>
</table>
# Neulasta

## Products Affected
- FULPHILA
- NEULASTA
- UDENYCA

## Coverage Criteria

<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 undergoing PBPC collection and therapy</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>Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist. RS - prescribed by, or in consultation with, a physician with expertise in treating acute radiation syndrome. PBPC - prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in transplantation.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Cancer pts receiving chemo - 6 months, RS - 1 month, PBPC - 1 dose</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
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</tr>
<tr>
<td>Other Criteria</td>
<td>Cancer patients receiving chemotherapy, approve if the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, older patient [aged greater than or equal to 65 years]), history of previous chemotherapy or radiation therapy, pre-existing neutropenia, open wounds or active infection, poor performance status, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.</td>
</tr>
</tbody>
</table>
## Neupogen

### Products Affected
- NEUPOGEN

<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 with acute myeloid leukemia (AML) receiving chemotherapy, cancer patients receiving bone marrow transplantation (BMT), patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy, and patients with severe chronic neutropenia [SCN] (e.g., congenital neutropenia, cyclic neutropenia, idiopathic neutropenia). Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL). Radiation Syndrome. Radiation induced neutropenia.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion Criteria</th>
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<thead>
<tr>
<th>Required Medical Information</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Age Restrictions</th>
<th>AML, HIV/AIDS, MDS - adults</th>
</tr>
</thead>
</table>

| Prescriber Restrictions | Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS. Radiation syndrome prescribed by, or in consultation with, a physician with expertise in treating RS. RIN oncologist, radiologist, or radiation oncologist. |

<table>
<thead>
<tr>
<th>Coverage Duration</th>
<th>chemo/SCN/AML-6 mo.HIV/AIDS-4 mo.MDS-3 mo.PBPC,Drug induce A/N,AA,ALL,BMT,RS-1 mo.All others=12mo.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, older patient [aged greater than or equal to 65 years], history of previous chemotherapy or radiation therapy, pre-existing neutropenia, open wounds or active infection, poor performance status), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, Neulasta, Neupogen) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be greater than 10 days in duration, invasive fungal infection). RIN patient is not currently receiving chemotherapy.</td>
</tr>
</tbody>
</table>
**Nexavar**

**Products Affected**
- NEXAVAR

<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 Nexavar for a covered use, osteosarcoma, angiosarcoma, advanced or unresectable desmoids tumors, gastrointestinal stromal tumors (GIST), medullary thyroid carcinoma, Acute Myeloid Leukemia, chordoma.</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></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>Osteosarcoma, approve if the patient has tried standard chemotherapy and have relapsed/refractory or metastatic disease. GIST, approve if the patient has tried THREE of the following: imatinib mesylate (Gleevec), sunitinib (Sutent), or regorafenib (Stivarga). Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma (DTC), approve if the patient is refractory to radioactive iodine treatment. Medullary thyroid carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq).</td>
</tr>
</tbody>
</table>
## Ninlaro

### Products Affected

- NINLARO

<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 FDA-approved indications not otherwise excluded. Plus, patients already started on Ninlaro.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
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<tr>
<td><strong>Required Medical Information</strong></td>
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<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization for 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>MM - must be used in combination with Revlimid and dexamethasone AND pt had received at least ONE previous therapy for multiple myeloma (e.g., Velcade [bortezomib injection], Kyprolis [carfilzomib intravenous {IV} infusion], Thalomid® [thalidomide capsules], Revlimid [lenalidomide capsules], Pomalyst® [pomalidomide capsules], Alkeran® [melphalan], dexamethasone, prednisone) OR Ninlaro is being used following autologous stem cell transplantation.</td>
</tr>
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</table>
## Nivestym

### Products Affected
- NIVESTYM

<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 with acute myeloid leukemia (AML) receiving chemotherapy, cancer patients receiving bone marrow transplantation (BMT), patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy, and patients with severe chronic neutropenia [SCN] (e.g., congenital neutropenia, cyclic neutropenia, idiopathic neutropenia). Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL). Radiation Syndrome. Radiation induced neutropenia.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion Criteria</th>
<th></th>
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<tbody>
<tr>
<td><strong>Required Medical Information</strong></td>
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<tr>
<th>Age Restrictions</th>
<th>AML, HIV/AIDS, MDS - adults</th>
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</thead>
<tbody>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS. Radiation syndrome prescribed by, or in consultation with, a physician with expertise in treating RS. RIN oncologist, radiologist, or radiation oncologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>chemo/SCN/AML-6 mo.HIV/AIDS-4 mo.MDS-3 mo.PBPC,Drug induce A/N,AA,ALL,BMT,RS-1 mo.All others=12mo.</td>
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<tr>
<td>-------------</td>
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</tr>
<tr>
<td>Other Criteria</td>
<td>Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, older patient [aged greater than or equal to 65 years], history of previous chemotherapy or radiation therapy, pre-existing neutropenia, open wounds or active infection, poor performance status), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, Neulasta, Neupogen) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be greater than 10 days in duration, invasive fungal infection). RIN patient is not currently receiving chemotherapy.</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 FDA-approved indications not otherwise excluded.</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>Asthma: 6 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 will be for 6 months initial, 12 months continuation.</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: 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 AND Patients asthma continues to be uncontrolled as defined by ONE of the following  A. patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, B. patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year C. patient has a FEV1 less than 80 percent predicted D. Patient has an FEV1/FVC less than 0.80, E. Patients 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 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>
## Nuedexta

### Products Affected
- NUEDEXTA

<table>
<thead>
<tr>
<th>PA Criteria</th>
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<tbody>
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<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded.</td>
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<tr>
<td><strong>Exclusion Criteria</strong></td>
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<tr>
<td><strong>Required Medical Information</strong></td>
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</tr>
<tr>
<td><strong>Age Restrictions</strong></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 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
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</tbody>
</table>
# Ocaliva

## Products Affected

- **OCALIVA**

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded. Plus patients already started on Ocaliva 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>Prescriber specialty, lab values, prior medications used for diagnosis and length of trials</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>18 years and older (initial and continuation therapy)</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician (initial and continuation therapy)</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>6 months initial, 3 years cont</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Initial treatment of PBC-Patient must meet both 1 and 2-1. Patient has a diagnosis of PBC as defined by TWO of the following: a) Alkaline phosphatase (ALP) elevated above the upper limit of normal as defined by normal laboratory reference values, b) Positive anti-mitochondrial antibodies (AMAs), c) Histologic evidence of primary biliary cholangitis (PBC) from a liver biopsy. Patient meets ONE of the following: a) Patient has been receiving ursodiol therapy for greater than or equal to 1 year and has had an inadequate response. b) Patient is unable to tolerate ursodiol therapy. Cont tx - approve if the patient has responded to Ocaliva therapy as determined by the prescribing physician (e.g., improved biochemical markers of PBC (e.g., alkaline phosphatase [ALP], bilirubin, gamma-glutamyl transpeptidase [GGT], aspartate aminotransferase [AST], alanine aminotransferase [ALT] levels))</td>
</tr>
</tbody>
</table>
# OCREVUS

**Products Affected**
- OCREVUS

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
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<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></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>Authorization will be for 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
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</tr>
</tbody>
</table>
# Ofev

## Products Affected

- OFEV

<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>Combination use with pirfenidone (Esbriet).</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>The patient is aged greater than or equal to 40 years old.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with a pulmonologist.</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>IPF baseline - must have FVC greater than or equal to 50% of the predicted value and IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.</td>
</tr>
</tbody>
</table>
## Orilissa

### Products Affected

- ORILISSA

<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>Pregnancy, osteoporosis, severe hepatic impairment</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Hepatic function</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 obstetrician-gynecologist or a health care practitioner who specializes in the treatment of women's health</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial - 6 months and total approval duration not to exceed 24 months (150 mg once daily dosing)</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Initial, approve if patient has moderate to severe endometriosis pain and has tried one of the following: a contraceptive (combination oral contraceptives, levonorgestrel-releasing intrauterine systems), or a progesterone product unless contraindicated, an exception to the requirement for a trial of the above can be made if there has been prior trial of a gonadotropin-releasing hormone (GnRH) agonist, AND the patient has continued to experience moderate to severe pain associated with endometriosis after treatment with one of the above mentioned agents, unless contraindicated. Continuation, approve if the patient has responded to treatment as determined by the prescribing physician.</td>
</tr>
</tbody>
</table>
## Orkambi

### Products Affected
- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

<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 FDA-approved indications not otherwise excluded.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Combination use with Kalydeco or Symdeko</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>2 years of age and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Orkambi is prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of CF.</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>CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)</td>
</tr>
</tbody>
</table>
## Oxervate

### Products Affected
- **OXERVATE**

<table>
<thead>
<tr>
<th><strong>PA Criteria</strong></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded.</td>
</tr>
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<td><strong>Exclusion Criteria</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis</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 ophthalmologist</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 2 months</td>
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<tr>
<td><strong>Other Criteria</strong></td>
<td>None</td>
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### Palynziq

**Products Affected**
- PALYNZIQ

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</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, phenylalanine concentrations</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>18 years and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Approval for 1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Initial therapy - approve if the patient has uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on at least one existing treatment modality (e.g., restriction of dietary phenylalanine and protein intake, prior treatment with Kuvan). Maintenance therapy - approve if the patient's blood phenylalanine concentration is less than or equal to 600 micromol/L OR the patient has achieved at least a 20% reduction in blood phenylalanine concentration from pretreatment baseline.</td>
</tr>
</tbody>
</table>
## Phosphodiesterase-5 Inhibitors for PAH

### Products Affected
- sildenafil (pulm.hypertension)

<table>
<thead>
<tr>
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<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>The agent is 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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Pulmonary Arterial Hypertension (PAH) [World Health Organization (WHO) Group 1]: the patient has a diagnosis of PAH (WHO Group 1) AND The patient has had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1) OR patient is currently Receiving the Requested Phosphodiesterase Type 5 (PDE5) inhibitor (i.e., Revatio tablets, Revatio suspension or Adcirca) or Another Agent Indicated for WHO Group 1.</td>
</tr>
</tbody>
</table>
## Piqray

### Products Affected
- PIQRAY

<table>
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<th>PA Criteria</th>
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<tbody>
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<td><strong>Covered Uses</strong></td>
<td>All FDA approved indications not otherwise 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, prior therapies</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>Approval duration of 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Approve if the patient meets the following criteria (A, B, C, D, and E): A) The patient is a postmenopausal female or a male AND B) The patient has advanced or metastatic hormone receptor (HR)-positive disease AND C) The patient has human epidermal growth factor receptor 2 (HER2)-negative disease AND D) The patient has PIK3CA-mutated breast cancer as detected by an approved test AND E) The patient has progressed on or after at least one prior endocrine-based regimen (e.g., anastrozole, letrozole, exemestane, Faslodex, tamoxifen, toremifene).</td>
</tr>
</tbody>
</table>
## Praluent

**Products Affected**

- PRALUENT PEN

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<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>Concurrent use of Juxtapid or Kynamro.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>LDL-C and response to other agents, prior therapies tried, medical history</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 cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization is for 12 months</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
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</tbody>
</table>
| Other Criteria | Hyperlipidemia in patients with HeFH without ASCVD - approve if meets all of the following 1. Pt has been diagnosed with HeFH AND 2. tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) AND 3. LDL-C remains greater than or equal to 70 mg/dL unless is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c.  
Hyperlipidemia Pt with Clinical ASCVD with or without HeFH - approve if meets all of the following has an LDL-C greater than or equal to 70 mg/dL (after treatment with antihyperlipidemic agents but prior to PCSK9 therapy), AND has one of the following conditions prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND tried ONE high intensity statin (as defined above) AND LDL-C remains greater than or equal to 70 mg/dL unless the pt is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. Non-Preferred drugs are also required to meet the non-preferred drugs criteria. |
# Promacta

## Products Affected
- PROMACTA

## 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 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></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>The patient must be 18 years or older for use in Patients with Chronic Immune (Idiopathic) Thrombocytopenia Purpura (ITP) and Thrombocytopenia in Patients with Chronic Hepatitis C.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>For treatment of Patients with Chronic Immune (Idiopathic) Thrombocytopenia Purpura (ITP) or Aplastic Anemia Promacta must be prescribed by in consultation with a hematologist. For treatment of Thrombocytopenia in Patients with Chronic Hep C Promacta must be prescribed by or in consultation with either a gastroenterologist, a hepatologist, or a physician that specializes in infectious disease.</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>Other Criteria</td>
<td>Treatment of Patients with Chronic Immune (Idiopathic) Thrombocytopenia Purpura (ITP). Approve Promacta if the patient meets the one of the following: The patient has tried corticosteroids OR The patient has tried IVIG OR The patient has undergone splenectomy. Treatment of Thrombocytopenia in Patients with Chronic Hepatitis C to Allow for Initiation and Maintenance of Interferon-Based Therapy. Approve Promacta if the patient meets the following: The patient has low platelet counts at baseline (pretreatment) [e.g., less than 75,000 mm³] AND The patient has chronic HCV infection and is a candidate for hepatitis C therapy (e.g., Pegasys or PegIntron plus ribavirin, with or without direct-acting antiviral agents [e.g., Victrelis™ {boceprevir capsules}, Incivek™ {telaprevir tablets}]). For Aplastic Anemia approve if the patient meets the following: The patient has low platelet counts at baseline (pretreatment) [e.g., less than 30,000 mm³] AND the patient has tried one immunosuppressant therapy (e.g., cyclosporine, mycophenolate moefetil, sirolimus, Atgam® [lymphocyte immune globulin, anti-thymocyte globulin [equine] sterile solution for intravenous use only}).</td>
</tr>
</tbody>
</table>
Pulmonary Arterial Hypertension Agents

Products Affected

- ADCIRCA
- ADEMPAS
- ambrisentan
- bosentan
- LEAIRIS
- OPSUMIT
- ORENITRAM
- REVATIO ORAL SUSPENSION FOR RECONSTITUTION
- REVATIO ORAL TABLET
- sildenafil (pulm. hypertension)
- tadalafil (pulm. hypertension)
- TRACLEER ORAL TABLET 125 MG, 62.5 MG
- TRACLEER ORAL TABLET FOR SUSPENSION 32 MG
- TYVASO
- TYVASO INSTITUTIONAL START KIT
- TYVASO REFILL KIT
- TYVASO STARTER KIT
- UPTRAVI
- VENTAVIS

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
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<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>The patient has a diagnosis of PAH (WHO Group 1)</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Must be prescribed by or in consultation with a cardiologist or a pulmonologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Authorization will be for 3 years</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For PAH patient must have had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Non-preferred drugs are also required to meet the non-preferred drug criteria.</td>
</tr>
</tbody>
</table>
# Repatha

## Products Affected
- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

<table>
<thead>
<tr>
<th>PA Criteria</th>
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<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Concurrent use of Juxtapid, Kynamro, or Praluent.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>ASCVD/HeFH - 18 yo and older, HoFH 13 yo and older.</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Authorization is 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>Hyperlipidemia in patients with HeFH without ASCVD - approve if meets all of the following: 1. Pt has been diagnosed with HeFH AND 2. tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) AND 3. LDL-C remains greater than or equal to 70 mg/dL unless is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. Hyperlipidemia Pt with Clinical ASCVD with or without HeFH - approve if meets all of the following: has an LDL-C greater than or equal to 70 mg/dL (after treatment with antihyperlipidemic agents but prior to PCSK9 therapy), AND has one of the following conditions prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND tried ONE high intensity statin (as defined above) AND LDL-C remains greater than or equal to 70 mg/dL unless the pt is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. HoFH - approve if meets all of the following: has one of the following genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus, OR untreated LDL-C greater than 500 mg/dL (prior to treatment with antihyperlipidemic agents), OR treated LDL-C greater than or equal to 300 mg/dL (after treatment with antihyperlipidemic agents but prior to agents such as Repatha, Kynamro or Juxtapid), OR have clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND tried ONE high intensity statin (as defined above) for greater than or equal to 8 weeks and LDL-C remains greater than or equal to 70 mg/dL unless is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. Non-preferred drugs also are required to meet the non-preferred drug criteria.</td>
</tr>
</tbody>
</table>
## Restasis

### Products Affected
- RESTASIS
- RESTASIS MULTIDOSE

<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. Worded as 2.Dry Eye Conditions due to Systemic Inflammatory Diseases (e.g., Sjögren syndrome, rheumatoid arthritis [RA], systemic lupus erythematosus [SLE]) and Dry Eye Conditions due to Ocular Surface Diseases (e.g., ocular rosacea, atopic keratoconjunctivitis, acute corneal graft rejection, blepharitis, herpetic stromal keratitis, conjunctival graft versus host disease [GVHD])</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Concomitant use with Xiidra (lifitegrast)</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis of Keratoconjunctivitis sicca (dry eye disease - includes dry eye associated with Sojogrens syndrome), use for prevention of corneal transplant rejection.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>16 years or older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>prescribed by an ophthalmologist or optometrist</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></td>
</tr>
</tbody>
</table>
# Retacrit

## Products Affected
- RETACRIT

<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 worded as anemia associated with chronic renal failure (CRF), including patients on dialysis and not on dialysis, and worded as anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia. Anemia due to myelodysplastic syndrome (MDS). Plus anemia in patients with HIV(with or without zidovudine). Patients using for perisurgical adjuvant therapy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion Criteria</th>
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</thead>
<tbody>
<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><strong>Coverage Duration</strong></td>
<td>CKD and MDS - Authorization will be for 6 months, Perisurgical - 1 month, Other - 4 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>Confirmation of adequate iron stores at initiation of therapy (eg, prescribing information recommends supplemental iron than or equal to 11 g/dL for children to start. Hb less than or equal to 11.5 g/dL for adults or 12 g/dL or less for children if currently on epoetin alfa or therapy when serum ferritin is less than 100 mcg/L or when serum transferrin saturation is less than 20%). CRF anemia in patients on and not on dialysis. Hemoglobin (Hb) of less than 10.0 g/dL for adults or less Aranesp. Anemia w/myelosuppressive chemotx. pt must be currently receiving myelosuppressive chemo and Hb 10.0 g/dL or less to start. Hb less than or equal to 12.0 g/dL if currently on epoetin alfa or Aranesp. MDS, approve if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start. Currently receiving Aranesp or EA, approve if Hb is 12.0 g/dL or less. Anemia in HIV (with or without zidovudine), Hb is 10.0 g/dL or less or endogenous erythropoetin levels are 500 munits/mL or less at tx start. Currently on EA approve if Hb is 12.0 g/dL or less. Perisurgical adjuvant therapy, patient is undergoing hip or knee surgery, has Hgb between 10 and 13 g/dL, is not a candidate for autologous blood transfusion.</td>
</tr>
</tbody>
</table>
# Revcovi

**Products Affected**
- REVCOVI

<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.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis</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>1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For initial therapy, the patient has failed or is not a candidate for bone marrow transplantation (BMT). For continuation of therapy, provider attests that disease is stable or has improved on therapy.</td>
</tr>
</tbody>
</table>
# Revlimid

## Products Affected
- REVLIMID

<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 Systemic Amyloidosis Light Chain, Diffuse Large B Cell Lymphoma (Non-Hodgkin's Lymphoma), Follicular Lymphoma (Non-Hodgkin's Lymphoma), Myelofibrosis, Castleman's Disease, Hodgkin lymphoma (Classical Systemic Light Chain Amyloidosis).</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis and previous therapies or drug regimens tried.</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 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>MCL-approve if the patient meets one of the following 1) Pt has tried two prior therapies or therapeutic regimens (eg, Velcade, HyperCVAD [cyclophosphamide, vincristine, doxorubicin, and dexamethasone alternating with high-dose methotrexate and cytarabine] + Rituxan [rituximab injection], the NORDIC regimen [dose-intensified induction immunochemotherapy with Rituxan + cyclophosphamide, vincristine, doxorubicin, prednisone alternating with Rituxan and high-dose cytarabine], RCHOP/RICE [Rituxan, cyclophosphamide, doxorubicin, vincristine, prednisone]/[Rituxan, Ifex (ifosfamide injection), carboplatin, etoposide], Treanda (bendamustine injection) plus Rituxan, Velcade (bortezomib injection) +/- Rituxan, cladribine + Rituxan, FC (fludarabine, cyclophosphamide) +/- Rituxan, PCR [pentostatin, cyclophosphamide, Rituxan]), or Imbruvica (ibrutinib capsules), OR 2) Pt has tried one prior therapy or therapeutic regimen (examples listed above) and cannot take Velcade according to the prescribing physician. MDS-approve if the patient meets one of the following: 1) Pt has symptomatic anemia, OR 2) Pt has transfusion-dependent anemia, OR 3) Pt has anemia that is not controlled with an erythroid stimulating agent (eg, Epogen, Procrit [epoetin alfa injection], Aranesp [darbepoetin alfa injection]). Diffuse, Large B Cell Lymphoma (Non-Hodgkin's Lymphoma)-approve if the pt has tried one other medication treatment regimen (eg, RCHOP, dose-adjusted EPOCH [etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin] + Rituxan, RCEPP [Rituxan, cyclophosphamide, etoposide, prednisone, procarbazine], DHAP [dexamethasone, cisplatin, cytarabine] +/- Rituxan, ICE [Ifex, carboplatin, etoposide] +/- Rituxan, and Treanda +/- Rituxan). Myelofibrosis-approve if the pt has tried one other therapy (eg, Jakafi [ruxolitinib tablets], androgens [eg, nandrolone, oxymetholone], Epogen, Procrit, Aranesp, prednisone, danazol, Thalomid [thalidomide capsules], melphalan, Myleran [busulfan tablets], alpha interferons, and hydroxyurea).</td>
</tr>
</tbody>
</table>
**Rituxan HyceLA**

**Products Affected**
- **RITUXAN HYCELA**

<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>Diagnosis, the patient has already received at least one full dose of Rituxan IV and administered under the care of a healthcare professional</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>Authorization will be for 1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Chronic Lymphocytic Leukemia (CLL) - Rituxan HyceLA will be given in combination with FC (fludarabine + cyclophosphamide)</td>
</tr>
</tbody>
</table>
## Rozlytrek

### Products Affected
- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

<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>None</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Solid Tumors - 12 years and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Solid Tumors-Approve if the patient meets the following criteria (A, B, and C): A) The patient has locally advanced or metastatic solid tumor and B) The patient’s tumor has neurotrophic receptor tyrosine kinase (NTRK) gene fusion C) The patient meets one of the following criteria (i or ii): i) The patient has progressed on prior therapies OR ii) There are no acceptable standard therapies and the medication is used as initial therapy. Non-Small Cell Lung Cancer-Approve if the patient has ROS1-positive metastatic disease.</td>
</tr>
</tbody>
</table>
# Rubraca

**Products Affected**
- RUBRACA

## PA Criteria

<table>
<thead>
<tr>
<th>Criteria Details</th>
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</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
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<tr>
<td><strong>Exclusion Criteria</strong></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
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<tr>
<td><strong>Other Criteria</strong></td>
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</tbody>
</table>
# RYDAPT

### Products Affected
- RYDAPT

## PA Criteria | Criteria Details
---|---
**Covered Uses** | All FDA-approved indications not otherwise excluded plus patients already started on Rydapt for Covered Use.
**Exclusion Criteria** |  
**Required Medical Information** | AML - genetic testing for FLT3 mutation
**Age Restrictions** |  
**Prescriber Restrictions** |  
**Coverage Duration** | Authorization will be for 3 years.
**Other Criteria** | AML - patient is FLT3-mutation positive AML as detected by an approved test.
## Santyl

### Products Affected
- SANTYL

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</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>None</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 3 months</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Signifor

### Products Affected
- SIGNIFOR

<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></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>Prescribed by or in consultation with an endocrinologist</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Acromegly - 1 year and Cushing's disease - 4 month initial and 1 year cont.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Acromegly - The patient has had an inadequate response to surgery and/or radiotherapy. OR The patient is NOT an appropriate candidate for surgery and/or radiotherapy. OR The patient is experiencing negative effects due to tumor size (e.g., optic nerve compression). AND The patient has (or had) a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal (ULN) based on age and gender for the reporting laboratory. Cushing's Disease - According to the prescribing physician, the patient is not a candidate for surgery, or surgery has not been curative.</td>
</tr>
</tbody>
</table>
**Solaraze**

**Products Affected**
- diclofenac sodium topical gel 3 %

<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. Diagnosis of Actinic Keratoses, Actinic Cheilitis (actinic keratoses of the lip[s]), Bowen's Disease, or Disseminated Superficial Actinic Porokeratosis (DSAP).</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Osteoarthritis</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></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization for 6 months.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For Disseminated Superficial Actinic Porokeratosis (DSAP) must have a trial of at least two other therapies used for the management of DSAP (e.g., topical 5-FU, imiquimod, topical corticosteroid, topical vitamin D3 analogues, topical or oral retinoid, cryotherapy, photodynamic therapy, and laser). For Bowen's Disease must have a trial of at least one other therapy used for the management of Bowen's disease (e.g., topical 5-fluorouracil [5-FU], imiquimod, cryotherapy, photodynamic therapy, curettage, excision, laser, or radiotherapy)</td>
</tr>
</tbody>
</table>
## Somatuline Depot

### Products Affected
- SOMATULINE DEPOT

<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></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>Acromegly - prescribed by or in consultation with an endocrinologist. Neuroendocrine Tumors, Carcinoid syndrome and pheochromocytoma/parganglioma - prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist.</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>Acromegly - The patient has had an inadequate response to surgery and/or radiotherapy. OR The patient is NOT an appropriate candidate for surgery and/or radiotherapy. OR The patient is experiencing negative effects due to tumor size (e.g., optic nerve compression). AND The patient has (or had) a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal (ULN) based on age and gender for the reporting laboratory.</td>
</tr>
</tbody>
</table>
Spravato

Products Affected

- SPRAVATO

<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>History of psychosis, unless prescriber believes benefits outweigh risks</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Prior therapies tried</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Patient is at least 18 years of age</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with a psychiatrist</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>6 months</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
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<tr>
<td>-------------</td>
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</tr>
<tr>
<td>Other Criteria</td>
<td>Initial Therapy: Approve for 6 months if the patient meets the following criteria: A) Patient is greater than 18 years of age, AND B) Patient has demonstrated nonresponse (less than or equal to 25% improvement in depression symptoms or scores) to at least two different antidepressants, each from a different pharmacologic class (e.g., selective serotonin reuptake inhibitors [SSRIs], serotonin-norepinephrine reuptake inhibitors [SNRIs], tricyclic antidepressants [TCAs], bupropion, mirtazapine, etc.) and each used at therapeutic dosages for at least 6 weeks in the current episode of depression, according to the prescribing physician, AND C) Patient is concomitantly receiving at least one oral antidepressant, AND D) Patient has one of the following (i or ii): i) No history of psychosis, OR ii) History of psychosis and the prescriber believes that the benefits of Spravato outweigh the risks, AND E) The patient’s history of controlled substance prescriptions has been checked using the state prescription drug monitoring program (PDMP), unless unavailable in the state (see note below), according to the prescribing physician, AND F) Spravato is being prescribed by a psychiatrist. Continuation Therapy: Patient must have responded, as determined by the prescriber. Note: Antidepressants may include, but are not limited to, selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), mirtazapine, and bupropion. Note: As of 03/08/2019, the state of Missouri is the only state in the US that does not have a PDMP program in place.</td>
</tr>
</tbody>
</table>
**Sprycel**

**Products Affected**
- SPRYCEL

<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 GIST and patients continuing treatment for an approved use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis for which Sprycel is being used. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.</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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For CML, new patient must have Ph-positive CML for approval of Sprycel. For ALL, new patient must have Ph-positive ALL for approval of Sprycel. GIST - pts has tried Strivarga, Sutent and Gleevec.</td>
</tr>
</tbody>
</table>
## Stivarga

### Products Affected
- STIVARGA

<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 Stivarga 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 for which Stivarga is being used. For metastatic colorectal cancer (CRC) and gastrointestinal stromal tumors (GIST), prior therapies tried. For metastatic CRC, KRAS mutation status.</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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For metastatic CRC with KRAS mutation, patient must have previously been treated with each of the following for approval: a fluoropyrimidine (eg, Xeloda, 5-FU), oxaliplatin, irinotecan. For metastatic CRC with no detected KRAS mutations (ie, KRAS wild-type), patient must have previously been treated with each of the following for approval: a fluoropyrimidine (eg, Xeloda, 5-FU), oxaliplatin, irinotecan, anti-EGFR therapy (eg, Eribitux, Vectibix). For GIST, patient must have previously been treated with imatinib (Gleevec) and sunitinib (Sutent). HCC approve is patient has previously tried Nexavar (sorafenib).</td>
</tr>
</tbody>
</table>
Strengiq

Products Affected

- STRENSIQ SUBCUTANEOUS SOLUTION
  40 MG/ML, 80 MG/0.8 ML

<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.</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>Authorization is for 12 months</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Sutent

Products Affected

- SUTENT

<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. Advanced, unresectable neuroendocrine tumors, chordoma, angiosarcoma, solitary fibrous tumor/hemangiopericytoma, alveolar soft part sarcoma (ASPS), differentiated (ie, papillary, follicular, and Hurthle) thyroid carcinoma, medullary thyroid carcinoma, thymic carcinoma, Solitary Fibrous Tumor/Hemangiopericytoma.</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>
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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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Gastrointestinal stromal tumors (GIST), approve if the patient has previously tried imatinib (Gleevec). Chordoma, approve if the patient has recurrent disease. Differentiated thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Medullary thyroid carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). Meningioma, approve if the patient has recurrent or progressive disease. Thymic carcinoma - has tried chemotherapy (e.g., carboplatin/paclitaxel) or radiation therapy.</td>
</tr>
</tbody>
</table>
Symdeko

Products Affected
• SYMDEKO

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Patients with unknown CFTR gene mutations.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis, specific CFTR gene mutations.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Twelve years of age and older.</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Authorization will be for 3 years.</td>
</tr>
</tbody>
</table>
## Synagis

### Products Affected
- SYNAGIS

<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Infant with Chronic Lung Disease (CLD) less than or equal to 2 years old. Infant with Congenital Heart Disease (CHD) less than or equal to 1 year old. Infant Born Prematurely less than or equal to 1 year old. Infant with Anatomic Pulmonary Abnormalities or a Neuromuscular Disorder less than or equal to 1 year old. Immunocompromised Child less than or equal to 2 years old. Child with Cardiac Transplant less than or equal to 2 years old.</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Infant with Congenital Heart Disease (CHD) prescribed by or in consultation with a cardiologist or an intensivist. Immunocompromised Child prescribed by or in consultation with immunologist or infectious disease specialist. Child with Cardiac Transplant prescribed by or in consultation with a cardiologist, intensivist, or transplant physician.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Approval duration of 5 months</td>
</tr>
<tr>
<td><strong>PA Criteria</strong></td>
<td><strong>Criteria Details</strong></td>
</tr>
<tr>
<td>-----------------</td>
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</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Preterm Infants with CLD: During the RSV season during the first year of life for preterm infants who develop CLD of prematurity defined as less than 32 weeks' gestation less than or equal to 31 weeks, 6 days) AND required greater than 21% oxygen for at least the first 28 days after birth. In the second year of life, only for infants who satisfy the above definition of CLD AND who continue to require medical support (i.e., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the second RSV season. Preterm infants born before 29 weeks' gestation (less than or equal to 28 weeks, 6 days): Infants born less than or equal to 28 weeks, 6 days' gestation who are less than 12 months at the start of the RSV season. For infants born during the RSV season, fewer than 5 monthly doses will be needed. Infants with anatomic pulmonary abnormalities or a neuromuscular disease: Infants with a congenital anomaly or neuromuscular disease that impairs the ability to clear secretions from the upper airway because of ineffective cough may be considered for Synagis prophylaxis during the first year of life. Infants with CHD: The infant is considered to have hemodynamically significant cyanotic CHD OR The infant has acyanotic heart disease AND is receiving medication to control heart failure AND will require cardiac surgical procedures OR The infant has moderate to severe pulmonary hypertension OR The infant has lesions that have been adequately corrected by surgery AND continues to require medication for congestive heart failure. Immunocompromised children: children less than 24 months of age who are profoundly immunocompromised during the RSV season (e.g., receiving chemotherapy, transplantation). Child with Cardiac Transplant: The child has undergone or will undergo cardiac transplantation during the current RSV season.</td>
</tr>
</tbody>
</table>
# Tafinlar

## Products Affected
- TAFINLAR

<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis for which Tafinlar is being used. For unresectable or metastatic melanoma must have documentation of BRAF V600E mutation.</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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Must have unresectable or metastatic melanoma with a BRAF V600 mutation, as detected by an FDA-approved test AND meets one of the following: Tafinlar will be used as monotherapy in a patient who has not previously experienced disease progression on prior BRAF inhibitor treatment (e.g., Zelboraf [vemurafenib tablets]) OR Tafinlar will be used in combination with Mekinist (trametinib tablets). For Non-small cell lung cancer (NSCLC) with BRAF V600E mutation</td>
</tr>
</tbody>
</table>
## Tagrisso

**Products Affected**
- TAGRISSO

<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>NSCLC - prior therapies and EGFR T790M mutation</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 for 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>NSCLC - Must have metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive NSCLC as detected by an approved test AND has progressed on or after one of Tarceva, Iressa, or Gilotrif therapy.</td>
</tr>
</tbody>
</table>
# Talzenna

## Products Affected
- TALZENNA

<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 Talzenna 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, BRCA mutation status, HER2 status</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>3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Locally-advanced or metastatic breast cancer-approve if the patient has germline BRCA mutation-positive  AND human epidermal growth factor receptor 2 (HER2) negative disease</td>
</tr>
</tbody>
</table>
# Tarceva

**Products Affected**

- erlotinib

<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 renal cell carcinoma (RCC) and continuation of treatment for an approved use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Advanced, recurrent, or metastatic non small cell lung cancer (NSCLC), EGFR mutation or gene amplification status.</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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Metastatic NSCLC, approve if the patient has EGFR exon 19 deletions or exon 21 (L858R) substitution mutations. Pancreatic locally advanced, unresectable, or metastatic cancer, approve if Tarceva is being prescribed in combination with gemcitabine. Advanced RCC, approve if the patient has non-clear cell histology.</td>
</tr>
</tbody>
</table>
# Tasigna

**Products Affected**
- TASIGNA

<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 Philadelphia positive Acute Lymphoblastic Leukemia (ALL) and Gastrointestinal Stromal Tumor (GIST) and patients continuing treatment 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 for which Tasigna is being used. For indication of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For indication of gastrointestinal stromal tumor (GIST) and ALL, prior therapies tried.</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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For CML, new patient must have Ph-positive CML for approval of Tasigna. For GIST, patient must have tried THREE of the following - sunitinib (Sutent), imatinib (Gleevec), or regorafenib (Strivarga). For ALL, Approve if the patient has tried two other tyrosine kinase inhibitors that are used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).</td>
</tr>
</tbody>
</table>
## Thalomid

### Products Affected
- THALOMID

<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 Discoid lupus erythematosus or cutaneous lupus erythematosus, Myelofibrosis, Prurigo nodularis, Recurrent aphthous ulcers or aphthous stomatitis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, Systemic Light Chain Amyloidosis.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion Criteria</th>
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<tbody>
<tr>
<td>Required Medical Information</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 3 years.</td>
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<td>PA Criteria</td>
<td>Criteria Details</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Discoid lupus erythematosus or cutaneous lupus erythematosus, approve if the patient has tried two other therapies (eg, corticosteroids [oral, topical, intralesional], hydroxychloroquine, tacrolimus [Protopic], methotrexate, dapsone, acitretin [Soriatane]). Myelofibrosis, approve if the patient has tried one other therapy (eg, ruxolitinib [Jakafi], danazol, epoetin alfa [Epogen/Procrit], prednisone, lenalidomide [Revlimid], hydroxyurea). Prurigo nodularis, approve if the patient has tried two other therapies (eg, azathioprine, capsaicin, psoralen plus ultraviolet A [PUVA] therapy, ultraviolet B [UVB] therapy). Recurrent aphthous ulcers or aphthous stomatitis, approve if the patient has tried two other therapies (eg, topical or intralesional corticosteroids, systemic corticosteroids, topical anesthetics/analgesics [eg, benzocaine lozenges], antimicrobial mouthwashes [eg, tetracycline], acyclovir, colchicine).</td>
</tr>
</tbody>
</table>
# Tibsovo

**Products Affected**
- TIBSOVO

<table>
<thead>
<tr>
<th>PA Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded. Plus patients already started on Tibsovo 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, IDH1 Status</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>Approval duration of 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>AML- approve if the patient has relapsed or refractory disease AND the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive.</td>
</tr>
</tbody>
</table>
# Topical Testosterone

## Products Affected
- **ANDRODERM**
- **ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)**
- **ANDROGEL TRANSDERMAL GEL IN PACKET 1 % (25 MG/2.5GRAM), 1 % (50 MG/5 GRAM), 1.62 % (20.25 MG/1.25 GRAM), 1.62 % (40.5 MG/2.5 GRAM)**
- **TESTOSTERONE TRANSDERMAL GEL**
- **testosterone transdermal gel in metered-dose pump**
- **testosterone transdermal gel in packet**
- **testosterone transdermal solution in metered pump w/app**

## 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. Endocrinologic masculization, delayed puberty (induction of puberty), or hypogonadism (primary or secondary).</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Not covered if used to enhance athletic performance.</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>Female-to-male gender reassignment - prescribed by, or in consultation with, an endocrinologist or a physician who specializes in the treatment of transgender patients.</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>Must not be used in male patients with carcinoma of the breast OR known or suspected carcinoma of the prostate. For First-Testosterone MC or First-Testosterone products must have tried one of the FDA-approved topical testosterone products [for example: Androderm, AndroGel, Axiron, testosterone 10mg/actuation gel (Fortesta), Striant, or testosterone gel 1% (Testim, Vogelxo)] for the current condition prior to approval. Non-preferred drugs are also required to meet the non-preferred drug criteria.</td>
</tr>
</tbody>
</table>
## Transmucosal Fentanyl

### Products Affected
- fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg

<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></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></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization will be for 12 months, unless otherwise specified.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate).</td>
</tr>
</tbody>
</table>
# Trikafta

## Products Affected
- TRIKAFTA

<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>Patients with unknown CFTR gene mutations Combination therapy with Orkambi, Kalydec or Symdeko</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, specific CFTR gene mutations, concurrent medications</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Twelve years of age and older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>CF - approve if the patient has at least one copy of the F508del mutation in the cystic fibrosis conductance regulator gene</td>
</tr>
</tbody>
</table>
## Triptodur

### Products Affected
- TRIPTODUR

<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 indication not otherwise excluded from coverage.</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></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>
## Tykerb

### Products Affected
- TYKERB

<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis for which Tykerb is being used. Metastatic breast cancer, HER2 status or hormone receptor (HR) status.</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 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>HER2-positive advanced or metastatic breast cancer, approve if Tykerb will be used in combination with Xeloda (capecitabine) or Herceptin and the patient has received prior therapy with Herceptin OR The patient is a postmenopausal OR The patient is a premenopausal or perimenopausal and is receiving ovarian suppression/ablation with a leutinizing hormone-releasing hormone (LHRH) agonist (e.g., Lupron [leuprolide], Trelstar [tiptorelin], Zoladex [goserelin]), surgical bilateral oophorectomy, or ovarian irradiation OR The patient is receiving a leutinizing hormone-releasing hormone (LHRH) agonist (e.g., Lupron [leuprolide], Trelstar [tiptorelin], Zoladex [goserelin]) AND Tykerb will be used in combination with an aromatase inhibitor (that is, letrozole, anastrozole, or exemestane)</td>
</tr>
</tbody>
</table>
# Tymlos

## Products Affected
- **TYMLOS SUBCUTANEOUS PEN INJECTOR 80 MCG (3,120 MCG/1.56 ML)**

## PA Criteria | Criteria Details
--- | ---
**Covered Uses** | All FDA-approved indications not otherwise excluded.
**Exclusion Criteria** | Concomitant use with other medications for osteoporosis (e.g., Prolia [denosumab for SC injection], bisphosphonates [alendronate, risedronate, ibandronate, zoledronic acid injection {Reclast}], calcitonin nasal spray, Tymlos [abaloparatide injection for SC use]), except calcium and Vitamin D. Previous Use of Forteo and/or Tymlos for a Combined total no greater than 2 years duration during a patient's Lifetime.

## Required Medical Information

## Age Restrictions

## Prescriber Restrictions

## Coverage Duration | Authorization will be for up to 2 years in a patient's lifetime.

## Other Criteria
Treatment of PMO, osteoporosis in men, and glucocorticoid-induced osteoporosis, approve if pt has tried one oral bisphosphonate for at least 12 months with an inadequate response OR the patient has experienced intolerability to an oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had multiple osteoporotic fractures.
# Venclexta

**Products Affected**
- VENCLEXTA
- VENCLEXTA STARTING PACK

## PA Criteria | Criteria Details
--- | ---
**Covered Uses** | All FDA-approved indications not otherwise excluded. Plus patients currently taking Venclexta for a Covered Use.
**Exclusion Criteria** | 
**Required Medical Information** | Diagnosis, prior therapy, 17p deletion status
**Age Restrictions** | 
**Prescriber Restrictions** | 
**Coverage Duration** | Authorization will be for 3 years.
<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Criteria</strong></td>
<td>CLL - approve if the patient has 17p deletion and has tried one prior therapy (e.g., Imbruvica® [ibrutinib capsules] high-dose methylprednisolone [HDMP] plus Rituxan® [rituximab for intravenous infusion] Gazyva® [obinutuzumab intravenous injection] plus chlorambucil Campath® [alemtuzumab for intravenous use] with or without Rituxan Zydelig® [idelalisib tablets] Zydelig plus Rituxan Revlimid® [lenalidomide capsules] with or without Rituxan Arzerra® [ofatumumab injection for intravenous use] or OFAR [oxaliplatin, fludarabine, cytarabine, Rituxan]) OR does not have a 17p deletion and has tried one prior therapy (e.g., Imbruvica Gazyva® [obinutuzumab intravenous injection] plus chlorambucil Arzerra® [ofatumumab injection for intravenous use] plus chlorambucil Rituxan® [rituximab for intravenous infusion] plus chlorambucil Gazyva Rituxan chlorambucil Treanda® (bendamustine injection) with or without Rituxan FCR (fludarabine, cyclophosphamide, Rituxan) FR (fludarabine, Rituxan), PCR (pentostatin, cyclophosphamide, Rituxan) Zydelig® [idelalisib tablets] Zydelig plus Rituxan high-dose methylprednisolone [HDMP] plus Rituxan] FC (fludarabine, cyclophosphamide) plus Arzerra Arzerra Revlimid with or without Rituxan, Campath® [alemtuzumab for intravenous use] with or without Rituxan RCHOP [Rituxan, cyclophosphamide, doxorubicin, vincristine, prednisone] or OFAR [oxaliplatin fludarabine, cytarabine, Rituxan]</td>
</tr>
</tbody>
</table>
Verzenio

Products Affected
• VERZENIO

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA approved indications not otherwise excluded from coverage.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>HR status, HER2 status, previous medications/therapies tried, concomitant therapy, menopausal status</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 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>Breast cancer in a woman - approve if 1) Patient has advanced or metastatic hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)] disease, AND 2) Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer, AND 3) Patient has not had disease progression while on Ibrance (palbociclib capsules), Kisqali (ribociclib tablets), or Verzenio, AND 4) Verzenio will be used in combination with anastrozole, exemestane, letrozole, or Faslodex (fulvestrant intramuscular injection), OR Verzenio will be used as monotherapy and the patient's breast cancer has progressed on at least one prior endocrine therapy (e.g., anastrozole, exemestane, letrozole, tamoxifen, Fareston [toremifene], exemestane plus Afinitor [everolimus], Faslodex [fulvestrant intramuscular injection], Afinitor plus Faslodex or tamoxifen, megestrol acetate, fluoxymesterone, ethinyl estradiol), and the patient has tried chemotherapy for metastatic breast cancer, AND 5) If pre/perimenopausal, the patient is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex [goserelin]), or has had surgical bilateral oophorectomy or ovarian irradiation. Breast cancer in Men - approve if 1) Patient has advanced or metastatic hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)] disease, AND 2) Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer, AND 3) Patient has not had disease progression while on Ibrance (palbociclib capsules), Kisqali (ribociclib tablets), or Verzenio, AND 4) Verzenio will be used in combination with Faslodex (fulvestrant intramuscular injection), OR Verzenio will be used as monotherapy and the patient's breast cancer has progressed on at least one prior endocrine therapy (e.g., anastrozole, exemestane, letrozole, tamoxifen, Fareston [toremifene], exemestane plus Afinitor [everolimus], Faslodex [fulvestrant intramuscular injection], Afinitor plus Faslodex or tamoxifen, megestrol acetate, fluoxymesterone, ethinyl estradiol), and the patient has tried chemotherapy for metastatic breast cancer, OR The patient is receiving a gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex [goserelin]) and Verzenio will be used in combination with anastrozole, exemestane, or letrozole.</td>
</tr>
</tbody>
</table>

| 159 |
## Vitrakvi

### Products Affected
- VITRAKVI

### Covered Uses
All FDA-approved indications not otherwise excluded.

### Exclusion Criteria
None

### Required Medical Information
Diagnosis, NTRK gene fusion status

### Age Restrictions
None

### Prescriber Restrictions
None

### Coverage Duration
3 years

### Other Criteria
Solid tumors - approve if the tumor has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation AND the tumor is metastatic or surgical resection of tumor will likely result in severe morbidity AND there are no satisfactory alternative treatments or the patient has disease progression following treatment.
## Vizimpro

### Products Affected
- VIZIMPRO

<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 Vizimpro 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, EGFR status, exon deletions or substitutions</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>3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Metastatic-NSCLC-Epidermal Growth Factor Receptor (EGFR) mutation positive AND has epidermal growth factor receptor (EGFR) exon 19 deletion as detected by an approved test OR exon 21 (L858R) substitution mutations as detected by an approved test.</td>
</tr>
</tbody>
</table>
**Votrient**

**Products Affected**
- VOTRIENT

<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 taking Votrient for a Covered Use. Differentiated (ie, papillary, follicular, Hurthle cell) thyroid carcinoma. Uterine sarcoma (advanced or metastatic), Dermatofibrosarcoma Protuberans (DFSP) with metastasis, Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer, Gastrointestinal Stromal Tumor (GIST), Medullary Thyroid Carcinoma</td>
</tr>
</tbody>
</table>

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
- Authorization will be for 3 years.
<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Criteria</td>
<td>Soft tissue sarcoma approve if advanced or metastatic AND patient has one of the following: angiosarcoma, pleomorphic rhabdomyosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma that is unresectable or progressive, Soft tissue sarcoma of the extremity/superficial trunk or head/neck, including synovial sarcoma or Other non-lipogenic (non-adipocytic) soft tissue sarcoma AND pt does not have GIST. Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Uterine sarcoma, approve if the patient has advanced or metastatic disease. Advanced RCC - approve. DFSP - approve if the patient has metastasis. Ovarian Cancer (ie, Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer) - approve if patient has persistent or recurrent disease or The patient has complete clinical remission after receiving primary treatment with chemotherapy (e.g., carboplatin with paclitaxel) and/or surgery. GIST - approve if the patient has tried THREE of the following: Gleevec, Sutent, or Strivarga. Medullary Thyroid Carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq).</td>
</tr>
</tbody>
</table>
**Vpriv**

**Products Affected**
- VPRIV

<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></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 1 year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Vyndaqel/Vyndamax

## Products Affected
- **VYNDAMAX**
- **VYNDAQEL**

## PA Criteria | Criteria Details
---|---
**Covered Uses** | All FDA-approved indications not otherwise excluded from coverage.

## Exclusion Criteria

## Required Medical Information
- Diagnosis

## Age Restrictions
- 18 years of age or older

## Prescriber Restrictions
- Prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis

## Coverage Duration
- Authorization will be for 1 year

## Other Criteria
- Approve if the patient meets ALL of the following (A, B, C, and D): A) The patient has genetic testing to identify a transthyretin (TTR) mutation (e.g., Val122Ile mutation, Thr60Ala mutation) or wild-type amyloidosis, AND B) The diagnosis was confirmed by one of the following (i or ii): i) A technetium pyrophosphate scan (i.e., nuclear scintigraphy), OR ii) Amyloid deposits are identified on cardiac biopsy, AND C) Diagnostic cardiac imaging (e.g., echocardiogram, cardiac magnetic imaging) has demonstrated cardiac involvement (e.g., increased thickness of the ventricular wall or interventricular septum), AND D) The patient has heart failure, but does not have New York Heart Association class IV disease.
### Xalkori

**Products Affected**
- XALKORI

<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. Additional coverage is provided for NSCLC with High Level MET Amplification or MET Exon 14 Skipping Mutation, Advanced or metastatic soft tissue sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK translocation and NSCLC with ROS1 Rearrangement. Plus patients already started on crizotinib 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>For the FDA-approved indication of NSCLC for patients new to therapy, ALK status and ROS1 rearrangement required. For soft tissue sarcoma IMT, ALK translocation.</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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>NSCLC metastatic, patient new to therapy must be ALK-positive or have ROS1 rearrangement for approval.</td>
</tr>
</tbody>
</table>
# Xenazine

## Products Affected

- tetrabenazine

## 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 FDA-approved or medically-accepted indications not otherwise excluded. Tardive dyskinesia (TD). Tourette syndrome and related tic disorders. Hyperkinetic dystonia. Hemiballism.</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>For treatment of chorea associated with Huntington's disease, Tourette syndrome or related tic disorders, hyperkinetic dystonia, or hemiballism, Xenazine must be prescribed by or after consultation with a neurologist. For TD, Xenazine must be prescribed by or after consultation with a neurologist or psychiatrist.</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></td>
</tr>
</tbody>
</table>
### Xenleta

#### Products Affected
- XENLETA

<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 Xenleta 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></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>None</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>1 month</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Community Acquired Pneumonia: Diagnosis must be confirmed via chest radiograph AND the member has a documented intolerance, adverse reaction, or resistance to at least two formulary alternatives from different antibiotic classes approved for CAP (macrolides, fluoroquinolones, beta-lactam, tetracycline (doxycycline))</td>
</tr>
</tbody>
</table>
## Xifaxan

### Products Affected
- XIFAXAN

<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.</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>
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<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Authorization will be for 1 year</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Xolair

## Products Affected
- XOLAIR

<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>Concurrent use with an interleukin (IL) antagonist monoclonal antibody (eg., Cinqair, Dupixent, or Nucala).</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>Moderate to severe persistent asthma-6 years and older. All other diagnoses-12 years and 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.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Authorization initial 4 months, continuation 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>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 immunosorbent 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 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). Continuing Xolair: approve if request meets prescriber restrictions AND patient has has responded to therapy as determined by the prescriber.</td>
</tr>
</tbody>
</table>
**Xospata**

**Products Affected**
- XOSPATA

<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>None</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, FLT3-mutation status</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>3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>AML - approve if the patient has relapsed or refractory disease AND the disease is FLT3-mutation positive as detected by an approved test.</td>
</tr>
</tbody>
</table>
# Xpovio

**Products Affected**
- XPOVIO

## 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 FDA-approved indications not otherwise 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, Prior therapies</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 3 years</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Approve if the patient meets ALL of the following (A, B, and C): A) The patient has tried at least two proteasome inhibitors. Note: Examples include Velcade (bortezomib injection), Kyprolis (carfilzomib infusion), Ninlaro (ixazomib capsules). AND B) The patient has tried at least two immunomodulatory drugs. Note: Examples include Revlimid (lenalidomide capsules), Pomalyset (pomalidomide capsules), Thalomid (thalidomide capsules). AND C) The patient has tried an anti-CD38 monoclonal antibody. Note: For example, Darzalex (daratumumab infusion).</td>
</tr>
</tbody>
</table>

Note: 
- Examples include Velcade (bortezomib injection), Kyprolis (carfilzomib infusion), Ninlaro (ixazomib capsules). AND
- B) The patient has tried at least two immunomodulatory drugs. Note: Examples include Revlimid (lenalidomide capsules), Pomalyset (pomalidomide capsules), Thalomid (thalidomide capsules). AND
- C) The patient has tried an anti-CD38 monoclonal antibody. Note: For example, Darzalex (daratumumab infusion).
**Xtandi**

**Products Affected**
- XTANDI

<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 or medically-accepted indications not otherwise excluded. Plus Prostate Cancer Non Metastatic, Castration Resistant and patients already started on Xtandi 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 for which Xtandi is being used. For metastatic castration-resistant prostate cancer, prior therapies tried.</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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For prostate cancer, patient must have metastatic, castration-resistant prostate cancer for approval.</td>
</tr>
</tbody>
</table>
## Yondelis

### Products Affected
- YONDELIS

<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Diagnosis, previous therapies tried</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 is for 12 months</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
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</tbody>
</table>
Zarxio

Products Affected
• ZARXIO

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded worded more broadly as cancer patients receiving myelosuppressive chemotherapy, patients with acute myeloid leukemia (AML) receiving chemotherapy, cancer patients receiving bone marrow transplantation (BMT), patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy, and patients with severe chronic neutropenia [SCN] (e.g., congenital neutropenia, cyclic neutropenia, idiopathic neutropenia). Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL). Radiation Syndrome. Radiation induced neutropenia.</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>AML, HIV/AIDS, MDS - adults</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS. RS physician with expertise in treating acute radiation injury (syndrome). RIN oncologist, radiologist or radiation oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>chemo/SCN/AML-6 mo.HIV/AIDS-4 mo.MDS-3 mo.PBPC,Drug induce A/N,AA,ALL,BMT-1 mo.All other=12mo.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
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</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, older patient [aged greater than or equal to 65 years], history of previous chemotherapy or radiation therapy, pre-existing neutropenia, open wounds or active infection, poor performance status), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, Neulasta, Neupogen) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm³], neutropenia expected to be greater than 10 days in duration, invasive fungal infection). RIN pt is not currently receiving chemotherapy</td>
</tr>
</tbody>
</table>
### ZEJULA

**Products Affected**
- ZEJULA

<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 Zejula for Covered Use.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
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<tr>
<td><strong>Age Restrictions</strong></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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Recurrent ovarian, fallopian tube, or primary peritoneal cancer - approve if the patient has received at least one prior platinum-based chemotherapy regimen and has had a complete or partial response AND Zejula is requested for maintenance treatment.</td>
</tr>
</tbody>
</table>
# Zelboraf

## Products Affected

- ZELBORAF

<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 Hair Cell Leukemia, NSCLC with BRAF V600E Mutation, Thyroid Cancer and patients already started on vemurafenib 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>For the FDA-approved indication of melanoma, for patients new to therapy, BRAFV600E status required.</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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Melanoma, patient new to therapy must have BRAFV600 mutation for approval AND patient meets ONE of the following conditions: Zelboraf will be used as monotherapy in a patient who has not previously experienced disease progression on prior BRAF inhibitor treatment (e.g., Tafinlar [dabrafenib capsules]) OR Zelboraf will be used in combination with Cotellic (cobimetinib tablets). HCL The patient has relapsed/refractory hairy cell leukemia AND The patient has tried at least two therapies for hairy cell leukemia (e.g., cladribine, Nipent™ [pentostatin injection], or cladribine or Nipent ± Rituxan® [rituximab injection], Rituxan, Intron® A [interferon alpha-2b injection]). Thyroid Cancer approved if The patient has differentiated thyroid carcinoma (i.e., papillary, follicular, or Hürthle cell) AND The patient has disease that is refractory to radioactive iodine therapy AND The patient has BRAF-positive disease.</td>
</tr>
</tbody>
</table>
## Zydelig

### Products Affected
- **ZYDELIG**

### PA Criteria

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
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<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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></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 3 years.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>CLL patient has tried one prior therapy (e.g., Imbruvica® [ibrutinib capsules], Gazyva® [obinutuzumab intravenous injection], chlorambucil, Arzerra® [ofatumumab injection for intravenous use], fludarabine, FCR [fludarabine, cyclophosphamide and Rituxan® [rituximab for intravenous injection]], FR [fludarabine plus Rituxan], PCR [pentostatin, cyclophosphamide, Rituxan], Treanda® [bendamustine injection], high-dose methylprednisolone [HDMP] plus Rituxan, Campath® [alemtuzumab for intravenous use], Venclexta® [venetoclax tablets], OFAR [oxaliplatin, fludarabine, cybarabine, Rituxan], or RCHOP [Rituxan, cyclophosphamide, doxorubicin, vincristine, prednisone]). Follicular B cell Non-Hodgkin Lymphoma patient has tried one prior therapy (e.g., Treanda® [bendamustine injection] plus Rituxan® [rituximab for intravenous injection], Rituxan, RCHOP [Rituxan, cyclophosphamide, doxorubicin, vincristine, prednisone]), RCVP [Rituxan, cyclophosphamide, vincristine, prednisone], chlorambucil, cyclophosphamide, Revlimid® [lenalidomide capsules], or fludarabine). SLL patient has tried one prior therapy (e.g., Imbruvica® [ibrutinib capsules], Rituxan® [rituximab for intravenous injection], Gazyva® [obinutuzumab intravenous injection], chlorambucil, Arzerra® [ofatumumab injection for intravenous use], fludarabine, FCR [fludarabine, cyclophosphamide and Rituxan], FR [fludarabine plus Rituxan], PCR [pentostatin, cyclophosphamide, Rituxan], Treanda® [bendamustine injection], high-dose methylprednisolone [HDMP], or chlorambucil).</td>
</tr>
</tbody>
</table>
## Zykadia

### Products Affected
- ZYKADIA ORAL CAPSULE

<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 Soft Tissue Sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK Translocation.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Must have metastatic NSCLC that is anaplastic lymphoma kinase (ALK)-positive.</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 3 years.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Patient has metastatic anaplastic lymphoma kinase (ALK)-positive NSCLC as detected by an approved test</td>
</tr>
</tbody>
</table>
Zytiga

Products Affected

- abiraterone
- ZYTIGA ORAL TABLET 500 MG

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded. Plus Prostate Cancer - locally advanced or metastatic, castration-sensitive</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 3 years</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Metastatic castration-resistance prostate cancer, approve if Zytiga is being used in combination with prednisone. Prostate Cancer - Locally Advanced or Metastatic, Castration-Sensitive Zytiga is used in combination with prednisone</td>
</tr>
</tbody>
</table>
Index
abiraterone .................................. 183
ACTEMRA SUBCUTANEOUS ............. 1
ADCIRCA ..................................... 116
ADEMPAS ..................................... 116
AFINITOR DISPERZ ......................... 3
AFINITOR ORAL TABLET 10 MG ...... 3
ALECENSA ..................................... 5
ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG ......................... 6
ALUNBRIG ORAL TABLETS, DOSE PACK ........................................... 6
ambrisentan ....................................... 116
ANDRODERM ................................ 150
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %) ...................... 150
ANDROGEL TRANSDERMAL GEL IN PACKET 1 % (25 MG/2.5GRAM), 1 % (50 MG/5 GRAM), 1.62 % (20.25 MG/1.25 GRAM), 1.62 % (40.5 MG/2.5 GRAM) ........................................... 150
ARIKAYCE ..................................... 10
ARYMO ER ..................................... 75
AUBAGIO ........................................ 88
AUSTEDO ........................................ 11
AVONEX (WITH ALBUMIN) ............ 88
AVONEX INTRAMUSCULAR PEN INJECTOR KIT .................................. 88
AVONEX INTRAMUSCULAR SYRINGE KIT ........................................... 88
BALVERSA ..................................... 12
BELBUCA ...................................... 75
BERINERT ....................................... 13
BETASERON ..................................... 88
bexarotene .................................... 14
bosentan ....................................... 116
BOSULIF ........................................ 15
BRAFTOVI ....................................... 16
BRUKINSA .................................... 17
buprenorphine transdermal patch weekly 10 mcg/hour, 15 mcg/hour, 20 mcg/hour, 5 mcg/hour ....................... 75
CABLIVI ......................................... 18
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG ......................... 19
CALQUENCE ..................................... 20
CAPRELSA ...................................... 21
CINRYZE ........................................ 22
COMETRIQ ...................................... 23
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML ....................... 88
COPIKTRA ....................................... 24
CORLANOR ..................................... 25
COTELIC ........................................... 26
CRYSVITA ....................................... 27
DAURISMO ..................................... 30
deferasirox oral tablet 360 mg, 90 mg .............................................. 67
deferasirox oral tablet, dispersible .......... 43
diclofenac sodium topical gel 3 % .... 131
DUPIXENT SUBCUTANEOUS SYRINGE 300 MG/2 ML .................... 31
DURAGESIC ...................................... 75
ELELYSO ........................................... 33
EMBEDA ORAL CAPSULE, ORAL ONLY, EXT. REL. PELL .................... 75
EMGALITY PEN .................................... 34
EMGALITY SYRINGE ................................ 34
ENBREL SUBCUTANEOUS RECON SOLN ........................................... 35
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML) ........................................... 35
ENBREL SURECLICK.......................... 35
ENDARI ........................................... 37
EPCLUSA ......................................... 58
ERIVEDGE ...................................... 40
ERLEADA ......................................... 41
erlotinib ........................................ 145
ESBRIET ORAL CAPSULE ............. 42
ESBRIET ORAL TABLET 267 MG, 801 MG ........................................... 42
everolimus (antineoplastic) .............. 3
EXALGO ER ...................................... 75
FABRAZYME ..................................... 44
FARYDAK ........................................... 45
FASENRA ......................................... 46
FASENRA PEN ..................................... 46
fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg 151
fentanyl transdermal patch 72 hour
100 mcg/hr, 12 mcg/hr, 25 mcg/hr,
37.5 mcg/hour, 50 mcg/hr, 62.5 mg/hour, 75 mcg/hr, 87.5 mg/hour

hydroxyprogesterone caproate......... 83
HYSINGLA ER..................................75
IBRANCE ORAL CAPSULE............... 61
ICLUSIG ORAL TABLET 15 MG, 45 MG................................. 62
IDHIFA........................................ 63
imatinib oral tablet 100 mg, 400 mg. 51
IMBRUVICA ORAL CAPSULE 140 MG,
70 MG...........................................64
IMBRUVICA ORAL TABLET 140 MG,
280 MG, 420 MG, 560 MG..............64
INLYTA.........................................65
IRESSA......................................... 66
JAKAFI......................................... 68
JYNARQUE................................. 69
KADIAN ORAL
CAPSULE, EXTEND.RELEASE PELLETS
10 MG, 100 MG, 20 MG, 200 MG, 30 MG, 40 MG, 50 MG, 60 MG, 80 MG... 75
KALYDECO ORAL GRANULES IN
PACKET 50 MG, 75 MG.....................70
KALYDECO ORAL TABLET............... 70
KISQALI........................................ 71
KISQALI FEMARA CO-PACK............... 71
ledipasvir-sofosbuvir.................... 58
LENVIMA......................................72
LETAIRIS..................................73, 116
LONSURF.....................................77
LORBRENA....................................78
LUMIZYME..................................79
LUPRON DEPOT............................. 80
LUPRON DEPOT (3 MONTH)............... 80
LUPRON DEPOT (4 MONTH)............... 80
LUPRON DEPOT (6 MONTH)............... 80
LUPRON DEPOT-PED........................ 80
LUPRON DEPOT-PED (3 MONTH)......... 80
LYNPARZA ORAL TABLET............... 81
MAVYRET....................................58
megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 800 mg/20 ml (20 ml)... 84
megestrol oral tablet..........................84
MEKINIST....................................85
MEKTOVI....................................86
methadone oral concentrate.......... 75
methadone oral solution 10 mg/5 ml, 5 mg/5 ml.............................75
methadone oral tablet 10 mg, 5 mg.. 75
methadone oral tablet, soluble.................. 75
MORPHABOND ER.................................. 75
morphine oral capsule, er multiphase 24 hr ........................................ 75
morphine oral capsule, extended release pellets ................. 75
morphine oral tablet 15 mg.......................... 75
morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg............................. 75
MOVANTIK........................................ 87
MS CONTIN................................... 75
MYALEPT........................................... 89
NATPARA........................................ 90
NERLYNX......................................... 91
NEULASTA....................................... 92
NEUPOGEN......................................... 94
NEXAVAR.......................................... 96
NINLARO........................................ 97
NIVESTYM......................................... 98
NORDITROPIN FLEXPRO......................... 54
NUCALA........................................... 100
NUCYNTA.......................................... 75
NUCYNTA ER.................................... 75
NUDEXTA........................................... 102
NUTROPIN AQ NUSPIN.......................... 54
OCALIVA........................................... 103
OCREVUS......................................... 104
OFEV................................................ 105
OMNITROPE.................................... 54
ONETOUCH ULTRA BLUE TEST STRIP .......... 53
ONETOUCH ULTRA2 METER..................... 53
ONETOUCH ULTRAMINI.......................... 53
ONETOUCH VERIO............................... 53
ONETOUCH VERIO FLEX.......................... 53
ONETOUCH VERIO IQ METER.................. 53
ONETOUCH VERIO SYSTEM........................ 53
OPANA ER ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG.................. 75
OXYCODONE ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG.................. 75
OXYCONTIN ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG.................. 75
oxymorphone oral tablet extended release 12 hr.................. 75
PALYNZIQ......................................... 109
PIQRAY............................................. 111
PRALUENT PEN................................... 112
PRECISION XTRA KETONE-GLUCOSE........ 53
PRECISION XTRA MONITOR.................... 53
PRECISION XTRA TEST.......................... 53
PROCIT............................................ 38
PRODIGY NO CODING............................ 53
PRODIGY POCKET METER........................ 53
PRODIGY VOICE GLUCOSE METER............... 53
PROMACTA........................................ 114
REBIF (WITH ALBUMIN).......................... 88
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML, 8.8 MCG/0.2 ML-22 MCG/0.5 ML (6)........... 88
REBIF TITRATION PACK.......................... 88
REPATHA PUSHTRONEX.......................... 117
REPATHA SURECLICK......................... 117
REPATHA SYRINGE............................... 117
RESTASIS......................................... 119
RESTASIS MULTIDOSE............................ 119
RETACRIT......................................... 120
REVATIO ORAL SUSPENSION FOR RECONSTITUTION........ 116
REVATIO ORAL TABLET.......................... 116
REVCOVI........................................... 122
REVLIMID......................................... 123
RITUXAN HYCELA.............................. 125
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG.......................... 126
RUBRACA......................................... 127
RUZURGI......................................... 7
RYBELSUS......................................... 52
RYDAPT........................................... 128
SAIZEN............................................ 54
SAIZEN SAIZENPREP.............................. 54
SANTYL........................................... 129