Health Pointe Direct Complete Plan (HMO I-SNP) Medicare Part D Plan

Prior Authorization Criteria
Last Updated 11/01/2020

Products Affected

- *adapalene 0.1% cream*
- *adapalene 0.1% gel*
- *adapalene 0.3% gel*
- *adapalene/benzoyl peroxide 0.1-2.5% gel*
- *avita 0.025% cream*
- *avita 0.025% gel*
- DIFFERIN 0.1% LOTION
- EPIDUO 0.3-2.5% GEL
- *tretinoin 0.01% gel*
- *tretinoin 0.025% cream*
- *tretinoin 0.025% gel*
- *tretinoin 0.04% gel*
- *tretinoin 0.05% cream*
- *tretinoin 0.05% gel*
- *tretinoin 0.1% cream*
- *tretinoin 0.1% gel*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— ACTEMRA 162MG/0.9ML AUTO-INJECTOR

— ACTEMRA 162MG/0.9ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis: Intolerance to or failure of therapy with 2 of the following: Enbrel, Humira OR Rinvoq. For polyarticular juvenile idiopathic arthritis: Intolerance to or failure of therapy with Humira AND Enbrel. For Giant Cell Arteritis: trial and failure of corticosteroids required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ACTIMMUNE 2000000UNIT/0.5ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Hematologist, Immunologist, or Genetic Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *alyq 20mg tab*

— tadalafil 20mg tab (PAH)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ADEMPAS 0.5MG TAB
- ADEMPAS 1.5MG TAB
- ADEMPAS 2.5MG TAB
- ADEMPAS 1MG TAB
- ADEMPAS 2MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For diagnosis of Pulmonary Arterial Hypertension, trial of one (1) of the following: Letairis, Opsumit or Tracleer. For diagnosis of Persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4), trial of prior therapy is not required.

Products Affected

- AFINITOR 10MG TAB (New Starts Only)
- AFINITOR 2.5MG TAB (New Starts Only)
- AFINITOR 5MG SUSP (New Starts Only)
- AFINITOR 7.5MG TAB (New Starts Only)
- *everolimus 5mg tab (New Starts Only)*
- AFINITOR 2MG SUSP (New Starts Only)
- AFINITOR 3MG SUSP (New Starts Only)
- AFINITOR 5MG TAB (New Starts Only)
- *everolimus 2.5mg tab (New Starts Only)*
- *everolimus 7.5mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist or an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ALECENSA 150MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ALINIA 100MG/5ML SUSP
- ALINIA 500MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For diarrhea due to giardiasis, trial of metronidazole is required. For diarrhea due to cryptosporidiosis, trial of metronidazole not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ALUNBRIG TAB STARTER PACK (New Starts Only)
- ALUNBRIG 30MG TAB (New Starts Only)
- ALUNBRIG 180MG TAB (New Starts Only)
- ALUNBRIG 90MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- APTIOM 200MG TAB (New Starts Only)
- APTIOM 400MG TAB (New Starts Only)
- APTIOM 600MG TAB (New Starts Only)
- APTIOM 800MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ARCALYST 220MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Rheumatology Specialist, Dermatology Specialist, or Immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ARIKAYCE 70.3MG/ML INH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has failed to achieve negative sputum cultures after at least 6 months of multidrug regimen therapy for MAC lung disease.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an Infectious Disease Specialist or Pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *aripiprazole 1mg/ml oral soln (New Starts Only)*
— *aripiprazole 10mg odt (New Starts Only)*
— *aripiprazole 15mg odt (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient is unable to swallow tablets AND Patient has tried and failed or was intolerant to risperidone ODT or solution AND olanzapine ODT or solution.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– AURYXIA 210MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- AUSTEDO 12MG TAB
- AUSTEDO 6MG TAB
- AUSTEDO 9MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For tardive dyskinesia: Member has failed to respond to a change, or is unable to switch current antidopaminergic therapy AND has a functional disability due to tardive dyskinesia. For chorea associated with Huntington's disease: Patient has intolerance to or failure of therapy with tetrabenazine.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist or Psychiatrist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- AYVAKIT 100MG TAB (New Starts Only)
- AYVAKIT 200MG TAB (New Starts Only)
- AYVAKIT 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BALVERSA 3MG TAB (New Starts Only)
- BALVERSA 4MG TAB (New Starts Only)
- BALVERSA 5MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– BAXDELA 450MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— BENLYSTA 200MG/ML AUTO-INJECTOR — BENLYSTA 200MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Member has active lupus nephritis OR severe active CNS lupus OR member is taking IV cyclophosphamide or other biologics.
Required Medical Info	For initial therapy: Member is required to be taking a concurrent corticosteroid unless contraindicated AND has trial and failure of one (1) of the following: hydroxychloroquine, methotrexate, azathioprine OR mycophenolate. For continuation therapy: documentation of disease improvement is required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Rheumatologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For initial therapy: Diagnosis of active systemic lupus erythematosus is defined by anti-double stranded DNA value of greater than 30 IU/mL OR low complement (C3/C4). For continuation therapy: lab values not required.

Products Affected

— BENZNIDAZOLE 100MG TAB

— BENZNIDAZOLE 12.5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist.
Coverage Duration	Approved for 3 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BOSULIF 100MG TAB (New Starts Only)
- BOSULIF 400MG TAB (New Starts Only)
- BOSULIF 500MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– BRAFTOVI 75MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BRIVIACT 10MG TAB (New Starts Only)
- BRIVIACT 100MG TAB (New Starts Only)
- BRIVIACT 50MG TAB (New Starts Only)
- BRIVIACT 10MG/ML ORAL SOLN (New Starts Only)
- BRIVIACT 25MG TAB (New Starts Only)
- BRIVIACT 75MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– BRUKINSA 80MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CABOMETYX 20MG TAB (New Starts Only)
- CABOMETYX 40MG TAB (New Starts Only)
- CABOMETYX 60MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CALQUENCE 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CAPLYTA 42MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed 2 of the following: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone OR e) ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— CAPRELSA 100MG TAB (New Starts Only)

— CAPRELSA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Endocrinologist or Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CARBAGLU 200MG SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CAYSTON 75MG INH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist or Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CERDELGA 84MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Clinical Genetics specialist and/or a Medical Biochemical Genetics specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– EMGALITY 100MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of episodic cluster headache AND has tried and failed verapamil.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with a Neurologist or Headache Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Headache specialist defined as a member of the United Council for Neurologic Subspecialties, American Headache Society, National Headache Foundation, or International Headache Society OR has a certificate of added qualification in headache medicine or by the American Board of Headache Management.

Products Affected

- AIMOVIG 140MG/ML AUTO-INJECTOR
- AIMOVIG 70MG/ML AUTO-INJECTOR
- EMGALITY 120MG/ML AUTO-INJECTOR
- EMGALITY 120MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has greater than or equal to 4 migraine days per month for the previous 3 months or longer AND has tried and failed a 3-month or greater trial of 2 of the 3 following drug classes: anticonvulsants, vasoactive agents, antidepressants.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with a Neurologist or Headache Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Headache specialist defined as a member of the United Council for Neurologic Subspecialties, American Headache Society, National Headache Foundation, or International Headache Society OR has a certificate of added qualification in headache medicine or by the American Board of Headache Management.

Products Affected

— CHOLBAM 250MG CAP

— CHOLBAM 50MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hepatologist or Pediatric Gastroenterologist.
Coverage Duration	Initial will be 3 months, then if criteria is met approved for the rest of the plan year.
Other Criteria	Renewal requires documentation of stable or improved liver function.

Products Affected

— CIMZIA 200MG INJ

— CIMZIA 200MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Rheumatoid Arthritis (RA): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Rinvoq. For Ankylosing Spondylitis (AS): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Cosentyx. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Plaque Psoriasis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx, Skyrizi OR Otezla. For Crohn's Disease: Intolerance to or failure of therapy with Humira. For Non-radiographic axial spondyloarthritis: Intolerance or failure of therapy with two non-steroidal anti-inflammatory drugs (NSAIDs).
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis, Non-radiographic axial spondyloarthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Crohn's Disease : Prescribed by, or in consultation with a Gastroenterology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– COLCHICINE 0.6MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	If for gout, trial of Mitigare required. If for Familial Mediterranean fever, trial of Mitigare is not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- COMETRIQ 100MG DAILY DOSE CARTON PACK (New Starts Only)
- COMETRIQ 60MG DAILY DOSE CARTON PACK (New Starts Only)
- COMETRIQ 140MG DAILY DOSE CARTON PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— COPIKTRA 15MG CAP (New Starts Only)

— COPIKTRA 25MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CORLANOR 5MG TAB
- CORLANOR 7.5MG TAB
- CORLANOR 5MG/5ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	The patient is on a maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication, or a hypersensitivity to beta blocker.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— COSENTYX 150MG/ML AUTO-INJECTOR

— COSENTYX 150MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Plaque Psoriasis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR soriatane. For Ankylosing Spondylitis (AS) or Psoriatic Arthritis: Requires failure of, or intolerance to methotrexate OR sulfasalazine. (Trial of methotrexate or sulfasalazine not required for AS with predominant axial involvement).
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with Rheumatology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– COTELLIC 20MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CYSTARAN 0.44% OPHTH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the treatment of corneal cystine crystal accumulation in patients with cystinosis.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Ophthalmologist or Medical Geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *dalfampridine 10mg er tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— DAURISMO 100MG TAB (New Starts Only)

— DAURISMO 25MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– DOPTELET 20MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For thrombocytopenia with chronic liver disease and scheduled to undergo a procedure: Member has a platelet count from the prior two weeks that shows less than 50,000 platelets per microliter.
Age Restrictions	
Prescriber Restriction	For chronic immune thrombocytopenia: Prescribed by, or in consultation with a Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *dronabinol 10mg cap*
— *dronabinol 2.5mg cap*
— *dronabinol 5mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of loss of appetite due to AIDS OR chemotherapy induced nausea and vomiting.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Products Affected

- DUPIXENT 200MG/ML PF SYRINGE
- DUPIXENT 300MG/2ML PF SYRINGE
- DUPIXENT 300MG/2ML AUTO-INJECTOR (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Atopic Dermatitis: Intolerance to, or failure of therapy of two (2) of the following: a medium to very high potency topical steroid, a topical calcineurin inhibitor OR an oral immunosuppressant. For Asthma: Prescriber attests that member has a history, within the last year, of at least 1 asthma exacerbation requiring one of the following: treatment with systemic corticosteroids OR emergency department visit OR hospitalization. For nasal polyps: Intolerance to, or failure of therapy of both of the following: an oral corticosteroid AND a nasal corticosteroid.
Age Restrictions	For Atopic Dermatitis: Member must be 6 years of age or older. For Asthma: Member must be 12 years of age or older. For Nasal polyps: Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with an Allergist, Immunologist, Pulmonologist, Dermatologist or ENT Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For atopic dermatitis: Member has moderate to severe atopic dermatitis defined as: 1) body surface area involvement of 10 percent or more OR chart documentation of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. 2) At least two (2) of the following: intractable pruritus (itching), cracking and oozing/bleeding of skin, OR impaired activities of daily living. For asthma: Member has moderate to severe asthma with an eosinophilic phenotype (documented baseline blood eosinophil concentration greater than or equal to 150 cells/mL) OR member has oral corticosteroid-dependent asthma. For nasal polyps: Bilateral nasal polyposis confirmed with sinus CT scan AND

PA Criteria	Criteria Details
	prescriber attests to moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain).

Products Affected

- ENBREL 25MG INJ
- ENBREL 25MG/0.5ML INJ
- ENBREL 25MG/0.5ML SYRINGE
- ENBREL 50MG/ML CARTRIDGE
- ENBREL 50MG/ML SURECLICK INJ
- ENBREL 50MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 20mg/wk. For Juvenile Idiopathic Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15 mg/week. For Plaque Psoriasis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR soriatane. For Ankylosing Spondylitis (AS) or Psoriatic Arthritis: Requires failure of, or intolerance to methothrexate OR sulfasalazine. (Trial of methotrexate or sulfasalazine not required for AS with predominant axial involvement).
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ENDARI 5000MG POWDER FOR ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SOFOSBUVIR/VELPATASVIR 400-100MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments.
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist.
Coverage Duration	Coverage duration of 12 weeks.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected

– EPIDIOLEX 100MG/ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of at least 1 anti-epileptic medication was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	Prescribed by a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ERIVEDGE 150MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of Odomzo required for locally advanced basal cell carcinoma.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ERLEADA 60MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FANAPT TITRATION PACK (New Starts Only)
- FANAPT 10MG TAB (New Starts Only)
- FANAPT 2MG TAB (New Starts Only)
- FANAPT 6MG TAB (New Starts Only)
- FANAPT 1MG TAB (New Starts Only)
- FANAPT 12MG TAB (New Starts Only)
- FANAPT 4MG TAB (New Starts Only)
- FANAPT 8MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— FARYDAK 10MG CAP (New Starts Only)

— FARYDAK 20MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— FASENRA 30MG/ML AUTO-INJECTOR

— FASENRA 30MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Peripheral blood eosinophil count of greater than or equal to 150 cells per microliter. History of one (1) or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s).
Age Restrictions	Member must be 12 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with an Allergy Specialist, Immunologist, or Pulmonary Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FERRIPROX 100MG/ML ORAL SOLN
- FERRIPROX 500MG TAB
- FERRIPROX 1000MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– FINTEPLA 2.2MG/ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of at least 1 anti-epileptic medication was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— FIRMAGON 120MG INJ (New Starts Only)

— FIRMAGON 80MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FYCOMPA 0.5MG/ML SUSP (New Starts Only)
- FYCOMPA 10MG TAB (New Starts Only)
- FYCOMPA 12MG TAB (New Starts Only)
- FYCOMPA 2MG TAB (New Starts Only)
- FYCOMPA 4MG TAB (New Starts Only)
- FYCOMPA 6MG TAB (New Starts Only)
- FYCOMPA 8MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– GALAFOLD 123MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation that member has an amenable glactosidase alpha gene (GLA) variant.
Age Restrictions	Member must be 16 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with a Medical Geneticist or a prescriber specialized in the treatment of Fabry disease.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– GATTEX 5MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Dependent on parenteral support for at least 12 months and at least 3 days per week.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- GILOTRIF 20MG TAB (New Starts Only)
- GILOTRIF 30MG TAB (New Starts Only)
- GILOTRIF 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- GENOTROPIN 0.2MG SYRINGE
- GENOTROPIN 0.4MG SYRINGE
- GENOTROPIN 0.6MG SYRINGE
- GENOTROPIN 0.8MG SYRINGE
- GENOTROPIN 1MG SYRINGE
- GENOTROPIN 12MG CARTRIDGE
- GENOTROPIN 1.2MG SYRINGE
- GENOTROPIN 1.4MG SYRINGE
- GENOTROPIN 1.6MG SYRINGE
- GENOTROPIN 1.8MG SYRINGE
- GENOTROPIN 2MG SYRINGE
- GENOTROPIN 5MG CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	The criteria for approval of growth hormones in adults require the diagnosis of Somatropin Deficiency Syndrome (defined by failure to stimulate Growth Hormone secretion (peak GH level of 10mcg/L or less) by one of the acceptable provocative tests). This may include adults who as children had Growth Hormone deficiency or adults with known pituitary disease.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BERINERT 500UNIT INJ
- HAEGARDA 2000UNT INJ
- *icatibant 10mg/ml syringe*
- TAKHZYRO 300MG/2ML INJ
- CINRYZE 500UNIT INJ
- HAEGARDA 3000UNT INJ
- RUCONEST 2100UNIT INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– HETLIOZ 20MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient is totally blind.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- JUXTAPID 10MG CAP
- JUXTAPID 20MG CAP
- JUXTAPID 30MG CAP
- JUXTAPID 40MG CAP
- JUXTAPID 5MG CAP
- JUXTAPID 60MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Untreated LDL greater than 500 mg/dL OR treated LDL greater than or equal to 300 mg/dL. Concurrent use of maximum statin dose (atorvastatin or rosuvastatin) and one other lipid lowering agent (include dates and reasons for discontinuation). For patients with statin intolerance, concurrent use of maximum statin dose not required. Chart documentation showing the most recent full lipid panel, including Apo-B within the past 12 months.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Lipidologist, Cardiologist, or an Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *amitriptyline 10mg tab (New Starts Only)*
— *amitriptyline 100mg tab (New Starts Only)*
— *amitriptyline 150mg tab (New Starts Only)*
— *amitriptyline 25mg tab (New Starts Only)*
— *amitriptyline 50mg tab (New Starts Only)*
— *amitriptyline 75mg tab (New Starts Only)*
— AMOXAPINE 100MG TAB (New Starts Only)
— AMOXAPINE 150MG TAB (New Starts Only)
— AMOXAPINE 25MG TAB (New Starts Only)
— AMOXAPINE 50MG TAB (New Starts Only)
— *clomipramine 25mg cap (New Starts Only)*
— *clomipramine 50mg cap (New Starts Only)*
— *clomipramine 75mg cap (New Starts Only)*
— *desipramine 10mg tab (New Starts Only)*
— *desipramine 100mg tab (New Starts Only)*
— *desipramine 150mg tab (New Starts Only)*
— *desipramine 25mg tab (New Starts Only)*
— *desipramine 50mg tab (New Starts Only)*
— *desipramine 75mg tab (New Starts Only)*
— *doxepin 10mg cap (New Starts Only)*
— *doxepin 10mg/ml oral soln (New Starts Only)*
— *doxepin 100mg cap (New Starts Only)*
— DOXEPIN 150MG CAP (New Starts Only)
— *doxepin 25mg cap (New Starts Only)*
— *doxepin 50mg cap (New Starts Only)*
— *doxepin 75mg cap (New Starts Only)*
— *imipramine pamoate 100mg cap (New Starts Only)*
— *imipramine pamoate 125mg cap (New Starts Only)*
— *imipramine pamoate 150mg cap (New Starts Only)*
— *imipramine pamoate 75mg cap (New Starts Only)*
— *imipramine 10mg tab (New Starts Only)*
— *imipramine 25mg tab (New Starts Only)*
— *imipramine 50mg tab (New Starts Only)*
— *paroxetine 10mg tab (New Starts Only)*
— *paroxetine 12.5mg er tab (New Starts Only)*
— *paroxetine 20mg tab (New Starts Only)*
— *paroxetine 25mg er tab (New Starts Only)*
— *paroxetine 30mg tab (New Starts Only)*
— *paroxetine 37.5mg er tab (New Starts Only)*
— *paroxetine 40mg tab (New Starts Only)*
— PAXIL 10MG/5ML SUSP (New Starts Only)
— PEXEVA 10MG TAB (New Starts Only)
— PEXEVA 20MG TAB (New Starts Only)
— PEXEVA 30MG TAB (New Starts Only)

— PEXEVA 40MG TAB (New Starts Only)
— *protriptyline 5mg tab (New Starts Only)*
— *trimipramine 25mg cap (New Starts Only)*
— *protriptyline 10mg tab (New Starts Only)*
— *trimipramine 100mg cap (New Starts Only)*
— *trimipramine 50mg cap (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires trial and failure of one of the following: SSRI (not including paroxetine), SNRI, OR bupropion. For diagnosis of nocturnal enuresis, trial and failure of other agents not required.
Age Restrictions	PA applies to members 65 years or older.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *disopyramide 100mg cap*
- NORPACE 100MG ER CAP
- *disopyramide 150mg cap*
- NORPACE 150MG ER CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires trial and failure of one of the following: beta-blocker, calcium channel blockers, OR flecainide.
Age Restrictions	PA applies to members 65 years or older.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- HUMIRA PEDIATRIC CROHN'S STARTER PACK SYRINGE (2) 40MG/0.4ML 80MG/0.8ML
- HUMIRA PEN - CROHN'S STARTER PACK 40MG/0.8ML INJ
- HUMIRA PEN - PSORIASIS STARTER PACK 40MG/0.8ML INJ
- HUMIRA 10MG/0.1ML SYRINGE
- HUMIRA 20MG/0.2ML SYRINGE
- HUMIRA 40MG/0.4ML PEN INJECTOR
- HUMIRA 40MG/0.8ML AUTO-INJECTOR
- HUMIRA PEDIATRIC CROHN'S STARTER PACK (3) 80MG/0.8ML INJ
- HUMIRA PEN - CROHN'S STARTER PACK 80MG/0.8ML INJ
- HUMIRA PEN - PSORIASIS STARTER PACK 80MG/0.8ML INJ
- HUMIRA 10MG/0.2ML SYRINGE
- HUMIRA 20MG/0.4ML SYRINGE
- HUMIRA 40MG/0.4ML SYRINGE
- HUMIRA 40MG/0.8ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 20mg/wk. For Juvenile Idiopathic Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15 mg/week. For Plaque Psoriasis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR soriatane. For Ankylosing Spondylitis (AS) or Psoriatic Arthritis: Requires failure of, or intolerance to methothrexate OR sulfasalazine. (Trial of methotrexate or sulfasalazine not required for AS with predominant axial involvement). For Ulcerative Colitis or Crohn's Disease: Requires failure of, or intolerance to one of the following: corticosteroid, azathioprine, methotrexate OR 6-mercaptopurine. For Hidradenitis Suppurativa (HS): patient must have at least 3 cysts AND failure of therapy with at least one (1) oral antibiotic. For Uveitis: Requires failure of, or intolerance to thearpy with a corticosteroid AND an immunosuppressant (methotrexate, mycophenolate mofetil, azathioprine, OR cyclosporine).
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Plaque Psoriasis and Hidradenitis Suppurativa(HS):Prescribed by, or in consultation with a Dermatology Specialist. For Crohn's Disease and Ulcerative Colitis: Prescribed by, or in consultation with a Gastroenterology Specialist. For Uveitis: Prescribed by, or in consultation with a Rheumatology specialist OR ophthalmologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- IBRANCE 100MG CAP (New Starts Only)
- IBRANCE 125MG CAP (New Starts Only)
- IBRANCE 75MG CAP (New Starts Only)
- IBRANCE 100MG TAB (New Starts Only)
- IBRANCE 125MG TAB (New Starts Only)
- IBRANCE 75MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— ICLUSIG 15MG TAB (New Starts Only)

— ICLUSIG 45MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— IDHIFA 100MG TAB (New Starts Only)

— IDHIFA 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of IDH2 mutation as detected by an FDA approved test.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- IMBRUVICA 140MG CAP (New Starts Only)
- IMBRUVICA 140MG TAB (New Starts Only)
- IMBRUVICA 280MG TAB (New Starts Only)
- IMBRUVICA 420MG TAB (New Starts Only)
- IMBRUVICA 560MG TAB (New Starts Only)
- IMBRUVICA 70MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist, Hemotologist, or Transplant specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– INCRELEX 40MG/4ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the long-term treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency (primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— INGREZZA 40MG CAP

— INGREZZA 80MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has failed to respond to a change, or is unable to switch current antidopaminergic therapy AND has a functional disability due to tardive dyskinesia.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a neurologist or psychiatrist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— INLYTA 1MG TAB (New Starts Only)

— INLYTA 5MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— INQOVI 5 TABLET PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– INREBIC 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hematologist or an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *paliperidone 1.5mg er tab (New Starts Only)*
— *paliperidone 3mg er tab (New Starts Only)*
— *paliperidone 6mg er tab (New Starts Only)*
— *paliperidone 9mg er tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For schizophrenia, patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. Previous agent trials not required for schizoaffective disorder.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ESBRIET 267MG CAP
- ESBRIET 267MG TAB
- ESBRIET 801MG TAB
- OFEV 100MG CAP
- OFEV 150MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Definitive diagnosis of idiopathic pulmonary fibrosis defined by the following: No known cause of lung fibrosis AND one of the following: A. Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) B. High-resolution computed tomography indicates definite UIP pattern C. High-resolution computed tomography indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP. For systemic sclerosis-associated interstitial lung disease (SSc-ILD) (nintedanib only): Requires intolerance to or failure of therapy with mycophenolate AND diagnosis of SSc-ILD with documentation of high-resolution computed tomography (HRCT) scan and pulmonary function tests (PFT), including forced vital capacity (FVC) and diffusing capacity for carbon monoxide (DLCO).
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Will not be used in combination with other medications used to treat IPF.

Products Affected

– IRESSA 250MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *itraconazole 100mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For onychomycosis, must fail terbinafine.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist, Pulmonary Specialist, or Dermatology Specialist.
Coverage Duration	Approved for 6 months.
Other Criteria	

Products Affected

- BIVIGAM 5GM/50ML INJ
- GAMMAGARD 10GM INJ
- GAMMAGARD 5GM INJ
- GAMMAPLEX 10GM/100ML INJ
- GAMMAPLEX 20GM/200ML INJ
- GAMUNEX 1GM/10ML INJ
- OCTAGAM 25GM/500ML INJ
- PANZYGA 10GM/100ML IV SOLN
- PANZYGA 2.5GM/25ML IV SOLN
- PANZYGA 5GM/50ML IV SOLN
- FLEBOGAMMA 10% INJ
- GAMMAGARD 2.5GM/25ML INJ
- GAMMAKED 1GM/10ML INJ
- GAMMAPLEX 10GM/200ML INJ
- GAMMAPLEX 5GM/50ML INJ
- OCTAGAM 2GM/20ML INJ
- PANZYGA 1GM/10ML IV SOLN
- PANZYGA 20GM/200ML IV SOLN
- PANZYGA 30GM/300ML IV SOLN
- PRIVIGEN 20GM/200ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- JAKAFI 10MG TAB (New Starts Only)
- JAKAFI 15MG TAB (New Starts Only)
- JAKAFI 20MG TAB (New Starts Only)
- JAKAFI 25MG TAB (New Starts Only)
- JAKAFI 5MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hematologist or an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- JYNARQUE 15MG TAB
- JYNARQUE 30MG TAB
- JYNARQUE 45/15 THERAPY PACK
- JYNARQUE 90/30 THERAPY PACK
- JYNARQUE 15/15MG PACK
- JYNARQUE 30/15MG PACK
- JYNARQUE 60/30 THERAPY PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has an eGFR of 25 ml/min/1.73m2 or greater.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Nephrologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KALYDECO 150MG TAB
- KALYDECO 25MG GRANULES
- KALYDECO 50MG GRANULES PACKET
- KALYDECO 75MG GRANULES PACKET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KEVZARA 150MG/1.14ML AUTO-INJECTOR
- KEVZARA 200MG/1.14ML AUTO-INJECTOR
- KEVZARA 150MG/1.14ML PF INJ
- KEVZARA 200MG/1.14ML PF INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Rinvoq.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KISQALI 200MG DAILY DOSE PACK (New Starts Only)
- KISQALI 400MG DAILY DOSE PACK (New Starts Only)
- KISQALI 600MG DAILY DOSE PACK (New Starts Only)
- KISQALI/FEMARA TAB CO-PACK 200MG (New Starts Only)
- KISQALI/FEMARA TAB CO-PACK 400MG (New Starts Only)
- KISQALI/FEMARA TAB CO-PACK 600MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– KORLYM 300MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— KOSELUGO 10MG CAP (New Starts Only)

— KOSELUGO 25MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Chart notes documentation is provided that indicates inoperable and symptomatic disease.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KUVAN 100MG POWDER FOR ORAL SOLN
- KUVAN 100MG TAB
- KUVAN 500MG POWDER FOR ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuing therapy the patient must have shown a 20% drop in Phenylalanine levels after 2 months of Kuvan treatment.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Medical Geneticist or Metabolic Physician.
Coverage Duration	Initial approval of 3 months, then if critieria is met, approved for the rest of the contract year.
Other Criteria	

Products Affected

- LENVIMA (10) 10MG PACK (New Starts Only)
- LENVIMA (12) 4MG PACK (New Starts Only)
- LENVIMA (14) PACK (New Starts Only)
- LENVIMA (18) PACK (New Starts Only)
- LENVIMA (20) 10MG PACK (New Starts Only)
- LENVIMA (24) PACK (New Starts Only)
- LENVIMA (4) 4MG PACK (New Starts Only)
- LENVIMA (8) 4MG PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *ambrisentan 10mg tab*

— *ambrisentan 5mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Cardiologist or Pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– LEUKINE 250MCG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of or intolerance to filgrastim-sndz (Zarxio) AND tbo-filgrastim (Granix).
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *lidocaine 5% patch*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Management of neuropathic pain associated with diabetic peripheral neuropathy and postherpetic neuralgia.
Exclusion Criteria	
Required Medical Info	Trial and failure of gabapentin of four weeks or more.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *lidocaine 5% ointment*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial and failure of topical lidocaine 2% gel/jelly.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- LINZESS 145MCG CAP
- LINZESS 290MCG CAP
- LINZESS 72MCG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— LONSURF 15-6.14MG TAB (New Starts Only)

— LONSURF 20-8.19MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— LORBRENA 100MG TAB (New Starts Only)

— LORBRENA 25MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— LYNPARZA 100MG TAB (New Starts Only)

— LYNPARZA 150MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– MAVYRET 100-40MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments.
Age Restrictions	Member must be 12 years of age or older, or weigh at least 45kg.
Prescriber Restriction	Prescribed by, or in consultation with a Gastroenterologist, Hepatologist, Infectious Disease Physician or Transplant Physician.
Coverage Duration	Coverage duration of 8 to 16 weeks. Applied consistent with current AASLD-IDSA guidance.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected

— *megestrol acetate 125mg/ml susp*

— *megestrol acetate 40mg/ml susp*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *megestrol acetate 20mg tab (New Starts Only)*

— *megestrol acetate 40mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— MEKINIST 0.5MG TAB (New Starts Only)

— MEKINIST 2MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– MEKTOVI 15MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— MOVANTIK 12.5MG TAB

— MOVANTIK 25MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— ABELCET 5MG/ML INJ
— *acetylcysteine 20% inh soln*
— *albuterol 0.21mg/ml (0.63mg/3ml) inh soln*
— *albuterol 0.83mg/ml (0.083%) inh soln*
— AMBISOME 50MG INJ
— AMINOSYN-PF 7% INJ
— *aprepitant 125mg cap*
— *aprepitant 40mg cap*
— ARANESP 10MCG/0.4ML SYRINGE
— ARANESP 100MCG/0.5ML SYRINGE
— ARANESP 200MCG/ML INJ
— ARANESP 25MCG/ML INJ
— ARANESP 300MCG/ML INJ
— ARANESP 40MCG/ML INJ
— ARANESP 500MCG/ML SYRINGE
— ARANESP 60MCG/0.3ML SYRINGE
— ASTAGRAF 1MG XL CAP
— AZASAN 100MG TAB
— *azathioprine 50mg tab*
— *budesonide 0.25mg/ml inh soln*
— *calcitriol 0.00025mg cap*
— *calcitriol 0.001mg/ml oral soln*
— *acetylcysteine 10% inh soln*
— *acyclovir 50mg/ml inj*
— *albuterol 0.417mg/ml (1.25mg/3ml) inh soln*
— *albuterol 1mg/ml (0.5%) inh soln*
— AMINOSYN II 10% INJ
— AMPHOTERICIN B 50MG INJ
— *aprepitant 125mg/80mg pack*
— *aprepitant 80mg cap*
— ARANESP 100MCG/ML INJ
— ARANESP 150MCG/0.3ML SYRINGE
— ARANESP 200MCG/0.4ML SYRINGE
— ARANESP 25MCG/0.42ML SYRINGE
— ARANESP 300MCG/0.6ML SYRINGE
— ARANESP 40MCG/0.4ML SYRINGE
— ARANESP 60MCG/ML INJ
— ASTAGRAF 0.5MG XL CAP
— ASTAGRAF 5MG XL CAP
— AZASAN 75MG TAB
— *budesonide 0.125mg/ml inh soln*
— *budesonide 0.5mg/ml inh soln*
— *calcitriol 0.0005mg cap*
— *cinacalcet 30mg tab*

— *cinacalcet 60mg tab*
— CLINIMIX E 2.75/5 INJ
— CLINIMIX E 4.25/5 INJ
— CLINIMIX E 5/20 INJ
— CLINIMIX 4.25/5 INJ
— CLINIMIX 5/20 INJ
— *cromolyn sodium 10mg/ml inh soln*
— CYCLOPHOSPHAMIDE 50MG CAP
— *cyclosporine modified 100mg/ml oral soln*
— CYCLOSPORINE MODIFIED 50MG CAP
— *cyclosporine 25mg cap*
— *doxercalciferol 0.0005mg cap*
— *doxercalciferol 0.0025mg cap*
— ENGERIX-B 20MCG/ML SYRINGE
— ENVARSUS 1MG ER TAB
— *everolimus 0.25mg tab*
— *everolimus 0.75mg tab*
— FREAMINE 6.9% INJ
— *gengraf 100mg/ml oral soln*
— *glucose 10% inj*
— GLUCOSE 100MG/ML/SODIUM CHLORIDE 0.0769 MEQ/ML INJ
— *heparin sodium porcine 1000unit/ml inj*
— *heparin sodium porcine 20000unit/ml inj*
— HEPATAMINE 8% INJ
— *cinacalcet 90mg tab*
— CLINIMIX E 4.25/10 INJ
— CLINIMIX E 5/15 INJ
— CLINIMIX 4.25/10 INJ
— CLINIMIX 5/15 INJ
— *clinisol 15% inj*
— CYCLOPHOSPHAMIDE 25MG CAP
— *cyclosporine modified 100mg cap*
— *cyclosporine modified 25mg cap*
— *cyclosporine 100mg cap*
— DIPHTHERIA/TETANUS TOXOID INJ
— *doxercalciferol 0.001mg cap*
— ENGERIX-B 10MCG/0.5ML SYRINGE
— ENVARSUS 0.75MG ER TAB
— ENVARSUS 4MG ER TAB
— *everolimus 0.5mg tab*
— FIASP 100UNIT/ML INJ
— *gengraf 100mg cap*
— *gengraf 25mg cap*
— GLUCOSE 100MG/ML/SODIUM CHLORIDE 0.0342 MEQ/ML INJ
— *granisetron 1mg tab*
— *heparin sodium porcine 10000unit/ml inj*
— *heparin sodium porcine 5000unit/ml inj*
— HUMULIN R 500UNIT/ML INJ

— IMOVAX 2.5UNIT/ML INJ
— *ipratropium bromide 0.02% inh soln*
— *levalbuterol 0.31mg inh soln*
— *levalbuterol 1.25mg inh soln*
— *levocarnitine 100mg/ml oral soln*
— MEDROL 2MG TAB
— *methylprednisolone 32mg tab*
— *methylprednisolone 8mg tab*
— *mycophenolate mofetil 250mg cap*
— *mycophenolic acid 180mg dr tab*
— NEBUPENT 300MG INH SOLN
— NOVOLOG 100UNIT/ML INJ
— *ondansetron 0.8mg/ml oral soln*
— *ondansetron 4mg odt*
— *ondansetron 8mg odt*
— *paricalcitol 0.001mg cap*
— *paricalcitol 0.004mg cap*
— *plenamine 15% inj*
— *prednisolone 10mg odt*
— PREDNISOLONE 3MG/ML ORAL SOLN
— *prednisone 1mg tab*
— *prednisone 10mg tab*
— *prednisone 2.5mg tab*
— PREDNISONE 5MG/ML ORAL SOLN
— *intralipid 200mg/ml inj*
— *ipratropium/albuterol 0.5-2.5mg/3ml inh soln*
— *levalbuterol 0.63mg inh soln*
— *levalbuterol 2.5mg inh soln*
— *levocarnitine 330mg tab*
— *methylprednisolone 16mg tab*
— *methylprednisolone 4mg tab*
— *mycophenolate mofetil 200mg/ml susp*
— *mycophenolate mofetil 500mg tab*
— *mycophenolic acid 360mg dr tab*
— NEPHRAMINE 5.4% INJ
— *nutrilipid 20% iv soln*
— *ondansetron 24mg tab*
— *ondansetron 4mg tab*
— *ondansetron 8mg tab*
— *paricalcitol 0.002mg cap*
— *pentamidine isethionate 50mg/ml inh soln*
— *prednisolone 1mg/ml oral soln*
— *prednisolone 15mg odt*
— *prednisolone 30mg odt*
— PREDNISONE 1MG/ML ORAL SOLN
— *prednisone 20mg tab*
— *prednisone 5mg tab*
— PREDNISONE 50MG TAB

- PREMASOL 10% INJ
- PROCALAMINE 3% INJ
- PROGRAF 0.2MG GRANULES PACKET
- PROGRAF 1MG GRANULES PACKET
- PROSOL 20% INJ
- PULMOZYME 1MG/ML INH SOLN
- RABAVERT 2.5UNIT/ML INJ
- RECOMBIVAX HB 10MCG/ML INJ
- RECOMBIVAX 10MCG/ML SYRINGE
- RECOMBIVAX 40MCG/ML INJ
- RECOMBIVAX 5MCG/0.5ML SYRINGE
- RETACRIT 10000UNIT/ML INJ
- RETACRIT 2000UNIT/ML INJ
- RETACRIT 3000UNIT/ML INJ
- RETACRIT 4000UNIT/ML INJ
- RETACRIT 40000UNIT/ML INJ
- SANDIMMUNE 100MG/ML ORAL SOLN
- *sirolimus 0.5mg tab*
- *sirolimus 1mg tab*
- *sirolimus 1mg/ml oral soln*
- *sirolimus 2mg tab*
- *tacrolimus 0.5mg cap*
- *tacrolimus 1mg cap*
- *tacrolimus 5mg cap*
- TDVAX 4-4UNIT/ML INJ
- TENIVAC SYRINGE
- TPN ELECTROLYTES INJ
- TRAVASOL 10% INJ
- TROPHAMINE 10% INJ
- VARUBI 90MG TAB
- ZORTRESS 0.25MG TAB
- ZORTRESS 0.5MG TAB
- ZORTRESS 0.75MG TAB
- ZORTRESS 1MG TAB

PA Criteria	Criteria Details
Covered Uses	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Exclusion Criteria	N/A
Required Medical Info	N/A
Age Restrictions	N/A

PA Criteria	Criteria Details
Prescriber Restriction	N/A
Coverage Duration	N/A
Other Criteria	N/A

Products Affected

- NATPARA 100MCG CARTRIDGE
- NATPARA 25MCG CARTRIDGE
- NATPARA 50MCG CARTRIDGE
- NATPARA 75MCG CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NERLYNX 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— NEXAVAR 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NINLARO 2.3MG CAP (New Starts Only)
- NINLARO 3MG CAP (New Starts Only)
- NINLARO 4MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NORTHERA 100MG CAP
- NORTHERA 200MG CAP
- NORTHERA 300MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NOXAFIL 100MG DR TAB
- *posaconazole 100mg dr tab*
- NOXAFIL 40MG/ML SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Physician or Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NUBEQA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For nonmetastatic castration-resistant prostate cancer (nmCRPC), failure of or intolerance to apalutamide (Erleada) required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NUCALA 100MG INJ
- NUCALA 100MG/ML AUTO-INJECTOR
- NUCALA 100MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Asthma diagnosis: Peripheral blood eosinophil count of greater than or equal to 150 cells per microliter. History of 2 or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s). For eosinophilic granulomatosis with polyangiitis (EGPA), confirmation of diagnosis required.
Age Restrictions	For Severe Asthma diagnosis: Member must be 6 years of age or older. For eosinophilic granulomatosis with polyangiitis (EGPA) diagnosis: Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with an Allergy Specialist, Immunologist, Pulmonary Specialist or Rheumatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NUEDEXTA 20-10MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of structural neurological condition as the cause of pseudobulbar affect AND disease severity demonstrated by a score of 13 or greater on the Center for Neurologic Study Lability Scale (CNS-LS).
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Member has tried and failed an SSRI.

Products Affected

— NUPLAZID 10MG TAB (New Starts Only)

— NUPLAZID 34MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *armodafinil 150mg tab*
- *armodafinil 200mg tab*
- *armodafinil 250mg tab*
- *armodafinil 50mg tab*
- *modafinil 100mg tab*
- *modafinil 200mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of narcolepsy, OR obstructive sleep apnea/hypopnea syndrome, OR shift work sleep disorder.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NUZYRA 150MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist.
Coverage Duration	Approved for 1 month subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— OCALIVA 10MG TAB

— OCALIVA 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hepatologist or Gastroenterologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For use in treatment of primary biliary cholangitis, patient has had an inadequate response to a year of therapy with ursodiol or experienced intolerance to ursodiol.

Products Affected

– ODOMZO 200MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— OLUMIANT 1MG TAB

— OLUMIANT 2MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Rinvoq.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with a Rheumatology specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– OPSUMIT 10MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Cardiologist or Pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FENTANYL 0.1MG BUCCAL TAB
- *fentanyl 0.2mg lozenge*
- *fentanyl 0.4mg lozenge*
- *fentanyl 0.6mg lozenge*
- *fentanyl 0.8mg lozenge*
- *fentanyl 1.6mg lozenge*
- FENTORA 200MCG BUCCAL TAB
- FENTORA 600MCG BUCCAL TAB
- FENTANYL 0.2MG BUCCAL TAB
- FENTANYL 0.4MG BUCCAL TAB
- FENTANYL 0.6MG BUCCAL TAB
- FENTANYL 0.8MG BUCCAL TAB
- *fentanyl 1.2mg lozenge*
- FENTORA 100MCG BUCCAL TAB
- FENTORA 400MCG BUCCAL TAB
- FENTORA 800MCG BUCCAL TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Breakthrough cancer pain and opioid tolerance. Documented tolerance to opioids defined as patients taking around the clock medicine consisting of at least 60mg of oral morphine daily, at least 25mcg of transdermal fentanyl per hour, at least 30mg of oxycodone daily, at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid daily for a week or longer.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ORENCIA 125MG/ML AUTO-INJECTOR
- ORENCIA 125MG/ML SYRINGE
- ORENCIA 50MG/0.4ML SYRINGE
- ORENCIA 87.5MG/0.7ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis: Intolerance to or failure of therapy with 2 of the following: Enbrel, Humira OR Rinvoq. For polyarticular juvenile idiopathic arthritis: Intolerance to or failure of therapy with Humira AND Enbrel. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ORENITRAM 0.125MG ER TAB
- ORENITRAM 0.25MG ER TAB
- ORENITRAM 1MG ER TAB
- ORENITRAM 2.5MG ER TAB
- ORENITRAM 5MG ER TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *nitisinone 10mg cap*
- *nitisinone 2mg cap*
- *nitisinone 5mg cap*
- ORFADIN 10MG CAP
- ORFADIN 2MG CAP
- ORFADIN 20MG CAP
- ORFADIN 4MG/ML SUSP
- ORFADIN 5MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— ORILISSA 150MG TAB

— ORILISSA 200MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has failure to, or intolerance to a non-steroidal anti-inflammatory drug (NSAID) AND a hormonal contraceptive.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an obstetrician/gynecologist or women's health/reproductive specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Member does not have known osteoporosis.

Products Affected

- ORKAMBI 100-125MG GRANULES PACKET
- ORKAMBI 188-150MG GRANULES PACKET
- ORKAMBI 100-125MG TAB
- ORKAMBI 200-125MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Lung function (FEV1, ppFEV1), 2) BMI, 3) Pulmonary exacerbation history to be collected initially and at continuation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist.
Coverage Duration	Initial and continuation approval of 6 months to assess required medical info.
Other Criteria	

Products Affected

– OSPHENA 60MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance to or failure of therapy with generic estradiol vaginal cream and PREMARIN VAGINAL CREAM.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- OTEZLA 28-DAY STARTER PACK
- OTEZLA 30MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For oral ulcers associated with Behcet's disease: Trial of topical triamcinolone 0.1% oral paste was ineffective, not tolerated, or contraindicated. For Psoriatic Arthritis requires intolerance to or failure of therapy with methotrexate (at least 20mg/wk). For Plaque Psoriasis: Failure of, or intolerance to, methotrexate at a dose of 15mg/week or failure of, or intolerance to, soriatane.
Age Restrictions	
Prescriber Restriction	For oral ulcers associated with Behcet's disease: Prescribed by, or in consultation with, a rheumatology specialist. For Psoriatic Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For oral ulcers associated with Behcet's disease: Diagnosis confirmed by the presence of oral ulcers AND at least two of the following: recurrent genital ulceration, eye lesions, skin lesions, positive pathergy test.

Products Affected

– OXBRYTA 500MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1. Trial of maximally tolerated hydroxyurea dose was ineffective, not tolerated or contraindicated. 2. Member has had at least 1 vaso-occlusive crisis in the prior 12 months, while on hydroxyurea (if applicable). 3. If prescriber is a hematologist at a Sickle Cell Center of Excellence, criteria 1 and 2 may be bypassed (Documentation is provided of the name of the center of excellence).
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– OXERVATE 0.002% OPHTH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Eye to be treated has never been treated with Oxervate in the past.
Age Restrictions	
Prescriber Restriction	Prescribed by an Ophthalmologist.
Coverage Duration	Approved for 3 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- PALYNZIQ 10MG/0.5ML SYRINGE
- PALYNZIQ 2.5MG/0.5ML SYRINGE
- PALYNZIQ 20MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Member is 18 years of age or older.
Prescriber Restriction	Prescribed by or in consultation with a Medical Geneticist or Metabolic Physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- PRALUENT 150MG/ML AUTO-INJECTOR
- PRALUENT 75MG/ML AUTO-INJECTOR
- REPATHA 120MG/ML CARTRIDGE
- REPATHA 140MG/ML AUTO-INJECTOR
- REPATHA 140MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initiation of therapy patient must: A) Have one of the following conditions: 1) prior clinical atherosclerotic cardiovascular disease (ASCVD) (see Other Criteria), 2) heterozygous familial hypercholesterolemia (HeFH) (see Other Criteria) 3) homozygous familial hypercholesterolemia (HoFH) (see Other Criteria) or 4) Primary hyperlipidemia other than HeFH and HoFH (see Other Criteria) AND B) Current LDL-C level is over 100 mg/dL or over 70 mg/dL with diabetes, AND one of the following requirements is met: 1) patient has been treated for 8 weeks or more with a high intensity statin (atorvastatin 40mg or greater OR rosuvastatin 20mg or greater), OR 2) patient is intolerant to statins demonstrated by the failure of 2 statins, including an attempt with a low- or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin). Criteria B) not required for HoFH. For continuation of therapy, patient must: A) have one of the following conditions: 1) prior clinical ASCVD (see Other Criteria), 2) HeFH (see Other Criteria), 3) HoFH (see Other Criteria), or 4) Primary hyperlipidemia other than HeFH and HoFH (see Other Criteria) AND B) member had 10% or greater reduction in LDL-C on PCSK9 inhibitor therapy.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.

PA Criteria	Criteria Details
Other Criteria	Clinical ASCVD defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure, prior stroke or transient ischemic attack, or peripheral arterial disease of presumed atherosclerotic origin. Diagnosis of HeFH must be confirmed by one of the following: 1) DNA-based evidence of mutation in the LDLR, Apo B, OR PCSK9 gain of function mutation, 2) Untreated LDL-C greater than 190 mg/dl AND tendon xanthomas in patient or first/second degree relative, 3) Untreated LDL-C greater than 190 mg/dl AND either first degree relative less than 60 years of age or second degree relative less than 50 years of age with premature heart disease, OR 4) untreated LDL-C greater than 190 mg/dl AND first or second degree relative with total cholesterol greater than 290 mg/dL. Diagnosis of HoFH confirmed by the following: 1) two parents diagnosed with HeFH OR genetic confirmation of LDL receptor mutation, AND 2) untreated total cholesterol greater 290 mg/dL or LDL-C greater 190 mg/dL, AND 3) either xanthomas present at 10 years of age or younger OR atherosclerotic disease at 20 years of age or younger. Diagnosis of primary hyperlipidemia (other than HeFH and HoFH) includes documentation of the diagnosis, which may include, but is not limited to the following conditions: Familial hyperchylomicronemia or Buerger-Gruetz Syndrome, Familial Combined Hyperlipidemia, Familial dysbetalipoproteinemia, Familial Triglyceridemia, Endogenous Hypertriglyceridemia.

Products Affected

- PEMAZYRE 13.5MG TAB (New Starts Only)
- PEMAZYRE 4.5MG TAB (New Starts Only)
- PEMAZYRE 9MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of FGFR2 fusion or other rearrangement, as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- PIQRAY 200MG DAILY DOSE PACK (New Starts Only)
- PIQRAY 250MG DAILY DOSE PACK (New Starts Only)
- PIQRAY 300MG DAILY DOSE 150MG PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of HR +/HER2- and PIK3CA-mutation: Used in combination with fulvestrant: Used following progession on or after an endocrine-based therapy.
Age Restrictions	
Prescriber Restriction	Prescribed by Hematologist or Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- POMALYST 1MG CAP (New Starts Only)
- POMALYST 2MG CAP (New Starts Only)
- POMALYST 3MG CAP (New Starts Only)
- POMALYST 4MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- LOKELMA 10GM PACKET
- LOKELMA 5GM PACKET
- VELTASSA 16.8GM POWDER FOR ORAL SUSP
- VELTASSA 25.2GM POWDER FOR ORAL SUSP
- VELTASSA 8.4GM POWDER FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has baseline persistent potassium level greater than 5.0 mmol/L.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Nephrologist, Cardiologist, or Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— PREVYMIS 240MG TAB

— PREVYMIS 480MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— CRINONE 4% VAGINAL GEL

— CRINONE 8% VAGINAL GEL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– PROLIA 60MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For osteoporosis: Trial of an oral bisphosphonate was not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- PROMACTA 12.5MG POWDER FOR ORAL SUSP
- PROMACTA 25MG POWDER FOR ORAL SUSP
- PROMACTA 50MG TAB
- PROMACTA 12.5MG TAB
- PROMACTA 25MG TAB
- PROMACTA 75MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– QBRELIS 1MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Approval requires attestation of patient's inability to swallow solid dosage forms of lisinopril.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– QINLOCK 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– RAVICTI 1.1GM/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires trial of sodium phenylbutyrate powder.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Metabolic Physician or Medical Geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- RELISTOR 12MG/0.6ML INJ
- RELISTOR 12MG/0.6ML SYRINGE
- RELISTOR 8MG/0.4ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the treatment of opioid-induced constipation (OIC) in adults with advanced illness who are receiving palliative care when response to laxative therapy has not been sufficient, member must have tried and failed lactulose.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 4 months, subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— RETEVMO 40MG CAP (New Starts Only)

— RETEVMO 80MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of RET mutation or RET gene fusion.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *sildenafil 20mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- REVLIMID 10MG CAP (New Starts Only)
- REVLIMID 15MG CAP (New Starts Only)
- REVLIMID 20MG CAP (New Starts Only)
- REVLIMID 2.5MG CAP (New Starts Only)
- REVLIMID 25MG CAP (New Starts Only)
- REVLIMID 5MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- REXULTI 0.25MG TAB (New Starts Only)
- REXULTI 0.5MG TAB (New Starts Only)
- REXULTI 1MG TAB (New Starts Only)
- REXULTI 2MG TAB (New Starts Only)
- REXULTI 3MG TAB (New Starts Only)
- REXULTI 4MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For schizophrenia, patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. For Major Depressive Disorder, patient has tried and failed or was intolerant to aripiprazole.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– RINVOQ 15MG ER TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 20mg/wk.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— ROZLYTREK 100MG CAP (New Starts Only)

— ROZLYTREK 200MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of ROS1 rearragement or NTRK gene fusion mutation required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- RUBRACA 200MG TAB (New Starts Only)
- RUBRACA 250MG TAB (New Starts Only)
- RUBRACA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– RUZURGI 10MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) confirmed with one of the following: Presence of voltage-gated calcium channel antibodies OR electrophysiologic compound muscle action potential test findings are consistent with LEMS.

Products Affected

— RYDAPT 25MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *vigabatrin 50mg/ml oral soln (New Starts Only)*
— *vigabatrin 500mg tab (New Starts Only)*
— *vigadrone 500mg oral soln (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SAPHRIS 10MG SL TAB (New Starts Only)
- SAPHRIS 2.5MG SL TAB (New Starts Only)
- SAPHRIS 5MG SL TAB (New Starts Only)
- SECUADO 3.8MG/24HR PATCH (New Starts Only)
- SECUADO 5.7MG/24HR PATCH (New Starts Only)
- SECUADO 7.6MG/24HR PATCH (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SIGNIFOR 0.3MG/ML INJ
- SIGNIFOR 0.6MG/ML INJ
- SIGNIFOR 0.9MG/ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Prescribed for the treatment of an adult patient with Cushing disease AND Pituitary surgery is not an option OR Pituitary surgery was not curative.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SIMPONI 100MG/ML AUTO-INJECTOR
- SIMPONI 50MG/0.5ML AUTO-INJECTOR
- SIMPONI 100MG/ML INJ
- SIMPONI 50MG/0.5ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Rheumatoid Arthritis (RA): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Rinvoq. For Ankylosing Spondylitis (AS): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Cosentyx. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Ulcerative Colitis: Intolerance to or failure of thearpy with Humira.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Ulcerative Colitis : Prescribed by, or in consultation with a Gastroenterology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— SIRTURO 100MG TAB

— SIRTURO 20MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— SIVEXTRO 200MG INJ

— SIVEXTRO 200MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SKYRIZI SYRINGE 150MG DOSE PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR soriatane.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *diclofenac sodium 3% gel*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SOLIQUA 100UNIT-0.033MG/ML PEN INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	One of the following: A) Member is unable to achieve an A1c of 7 or under after three (3) months of treatment with one of the following: i) a maximally dosed GLP-1 receptor agonist OR ii) basal insulin greater than or equal to thirty (30) units per day: OR B) member is currently using both basal insulin AND a GLP-1 receptor agonist.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SOLTAMOX 10MG/5ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SOMAVERT 10MG INJ
- SOMAVERT 15MG INJ
- SOMAVERT 20MG INJ
- SOMAVERT 25MG INJ
- SOMAVERT 30MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SPRITAM 1000MG ODT (New Starts Only)
- SPRITAM 250MG ODT (New Starts Only)
- SPRITAM 500MG ODT (New Starts Only)
- SPRITAM 750MG ODT (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member must have a trial or contraindication to generic levetiracetam.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SPRYCEL 100MG TAB (New Starts Only)
- SPRYCEL 140MG TAB (New Starts Only)
- SPRYCEL 20MG TAB (New Starts Only)
- SPRYCEL 50MG TAB (New Starts Only)
- SPRYCEL 70MG TAB (New Starts Only)
- SPRYCEL 80MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- STELARA 45MG/0.5ML INJ
- STELARA 45MG/0.5ML SYRINGE
- STELARA 90MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Plaque Psoriasis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx, Skyrizi OR Otezla.For Crohn's Disease and Ulcerative colitis: Intolerance to or failure of therapy with Humira.
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist. For Crohn's Disease and Ulcerative colitis: Prescribed by, or in consultation with a Gastroenterology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– STIVARGA 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SUCRAID 8500UNIT/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— SUNOSI 150MG TAB

— SUNOSI 75MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Failure of, or intolerance to one of the following: modafinil OR armodafinil.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Neurologist, Pulmonologist, or Sleep Medicine Physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Documentation of full nocturnal polysomnogram used to confirm diagnosis.

Products Affected

- SUTENT 12.5MG CAP (New Starts Only)
- SUTENT 25MG CAP (New Starts Only)
- SUTENT 37.5MG CAP (New Starts Only)
- SUTENT 50MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— SYMDEKO TAB 4-WEEK PACK

— SYMDEKO 50-75MG75MG PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with a Pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SYMPROIC 0.2MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *clovique 250mg cap*

— *trientine 250mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— TABRECTA 150MG TAB (New Starts Only)

— TABRECTA 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of MET exo 14 skipping mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— TAFINLAR 50MG CAP (New Starts Only)

— TAFINLAR 75MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— TAGRISSO 40MG TAB (New Starts Only)

— TAGRISSO 80MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— TALZENNA 0.25MG CAP (New Starts Only)

— TALZENNA 1MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *erlotinib 100mg tab (New Starts Only)*
— *erlotinib 150mg tab (New Starts Only)*
— *erlotinib 25mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *bexarotene 75mg cap (New Starts Only)*

— TARGRETIN 1% GEL (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TASIGNA 150MG CAP (New Starts Only)
- TASIGNA 200MG CAP (New Starts Only)
- TASIGNA 50MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— TAVALISSE 100MG TAB

— TAVALISSE 150MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with a Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TAZVERIK 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TEGSEDI 189MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by a Neurologist, Cardiologist, Hematologist, or other specialist experienced in the diagnosis and treatment of hereditary transthyretin-mediated amyloidosis.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Hereditary transthyretin-mediated amyloidosis confirmed by genetic sequencing AND amyloidosis confirmed by positive tissue biopsy or laser capture tandem mass spectrometry.

Products Affected

— *tetrabenazine 12.5mg tab*

— *tetrabenazine 25mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has chorea due to Huntington's Disease.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- THALOMID 100MG CAP (New Starts Only)
- THALOMID 150MG CAP (New Starts Only)
- THALOMID 200MG CAP (New Starts Only)
- THALOMID 50MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Infectious Disease Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TIBSOVO 250MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— TOBI PODHALER KIT 28MG PACK

— *tobramycin 60mg/ml inh soln*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Physician or Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- AMCINONIDE 0.1% CREAM
- *beser 0.05% lotion*
- *clobetasol propionate 0.05% e foam*
- *desonide 0.05% lotion*
- *tovet 0.05% e foam*
- AMCINONIDE 0.1% OINTMENT
- *betamethasone valerate 0.12% foam*
- *desonide 0.05% cream*
- *fluticasone propionate 0.05% lotion*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires trial of two formulary topical steroids.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– MULPLETA 3MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has a platelet count from the prior two weeks that shows less than 50,000 platelets per microliter.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *bosentan 125mg tab*
— *bosentan 62.5mg tab*
— TRACLEER 32MG TAB FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TRIKAFTA 100-50-75MG/150MG PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- QUDEXY 100MG XR CAP (New Starts Only)
- QUDEXY 150MG XR CAP (New Starts Only)
- QUDEXY 200MG XR CAP (New Starts Only)
- QUDEXY 25MG XR CAP (New Starts Only)
- QUDEXY 50MG XR CAP (New Starts Only)
- TOPIRAMATE 100MG ER CAP (New Starts Only)
- TOPIRAMATE 150MG ER CAP (New Starts Only)
- TOPIRAMATE 200MG ER CAP (New Starts Only)
- TOPIRAMATE 25MG ER CAP (New Starts Only)
- TOPIRAMATE 50MG ER CAP (New Starts Only)
- TROKENDI 100MG XR CAP (New Starts Only)
- TROKENDI 200MG XR CAP (New Starts Only)
- TROKENDI 25MG XR CAP (New Starts Only)
- TROKENDI 50MG XR CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed topiramate (TOPAMAX) AND Patient has a diagnosis of partial-onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome OR is using for prophylaxis of migraine headache.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— TUKYSA 150MG TAB (New Starts Only)

— TUKYSA 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TURALIO 200MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TYKERB 250MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Tykerb is prescribed in combination with capecitabine (Xeloda) AND The patient has advanced or metastatic breast cancer with tumor over-expression of HER2 AND The patient has received prior therapy including an anthracycline and a taxane and trastumab. Tykerb is prescribed in combination with letrozole for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *budesonide 9mg er tab*

— UCERIS 2MG/ACT FOAM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has active mild to moderate ulcerative colitis and has tried and failed or was intolerant to mesalamine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- UPTRAVI TITRATION PACK
- UPTRAVI 1200MCG TAB
- UPTRAVI 1600MCG TAB
- UPTRAVI 400MCG TAB
- UPTRAVI 800MCG TAB
- UPTRAVI 1000MCG TAB
- UPTRAVI 1400MCG TAB
- UPTRAVI 200MCG TAB
- UPTRAVI 600MCG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– VALCHLOR 0.016% GEL (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has received prior skin-directed therapy such as topical steroids.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VENCLEXTA 10MG TAB (New Starts Only)
- VENCLEXTA 10/100/50MG STARTING PACK (New Starts Only)
- VENCLEXTA 100MG TAB (New Starts Only)
- VENCLEXTA 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— VENTAVIS 10MCG/ML INH SOLN

— VENTAVIS 20MCG/ML INH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VERZENIO 100MG TAB (New Starts Only)
- VERZENIO 150MG TAB (New Starts Only)
- VERZENIO 200MG TAB (New Starts Only)
- VERZENIO 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VITRAKVI 100MG CAP (New Starts Only)
- VITRAKVI 25MG CAP (New Starts Only)
- VITRAKVI 20MG/ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of NTRK gene fusion mutation required.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VIZIMPRO 15MG TAB (New Starts Only)
- VIZIMPRO 30MG TAB (New Starts Only)
- VIZIMPRO 45MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *voriconazole 200mg inj*
- *voriconazole 40mg/ml susp*
- *voriconazole 200mg tab*
- *voriconazole 50mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Physician or Oncologist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– VOSEVI 400-100-100MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments.
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with a Gastroenterologist, Hepatologist, Infectious Disease Physician or Transplant Physician.
Coverage Duration	Coverage duration of 12 weeks.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected

– VOTRIENT 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VRAYLAR 1.5MG CAP (New Starts Only)
- VRAYLAR 3MG CAP (New Starts Only)
- VRAYLAR 6MG CAP (New Starts Only)
- VRAYLAR 1.5/3MG MIXED PACK (New Starts Only)
- VRAYLAR 4.5MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– VYNDAMAX 61MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) Diagnosis confirmed by one of the following: i) cardiac biopsy with positive congo red staining and ATTR confirmation by mass spectrometry or immunofluorescence staining ii) Myocardial uptake of Tc-PYP demonstrated by a greater than 1.5 heart-to-contralateral ratio or grade 2 or greater visual evidence B) Absence of light-chain or other forms of amyloidosis confirmed by all of the following: i) Serum kappa/lambda free light chain ratio 0.26 to 1.65 ii) Absence of monoclonal protein via serum protein immunofixation iii) Absence of monoclonal protein via urine protein immunofixation.
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with, a Cardiologist or other provider experienced in the treatment of cardiomyopathy of transthyretin-mediated amyloidosis.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— WAKIX 17.8MG TAB

— WAKIX 4.45MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy: failure of, or intolerance to both: A) Sunosi AND B) either modafinil OR armodafinil.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Neurologist, Pulmonologist, or Sleep Medicine Physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Documentation of full nocturnal polysomnogram used to confirm diagnosis of narcolepsy.

Products Affected

— XALKORI 200MG CAP (New Starts Only)

— XALKORI 250MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XATMEP 2.5MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For polyarticular juvenile idiopathic arthritis: patient must have trial of or inability to use oral methotrexate tablet. For acute lymphoblastic leukemia: trial of oral methotrexate tablet is not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— XELJANZ 10MG TAB

— XELJANZ 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Rheumatoid Arthritis (RA): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, or Rinvoq. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Ulcerative Colitis: Intolerance to or failure of therapy with Humira.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis or Psoriatic Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist. For Ulcerative Colitis : Prescribed by, or in consultation with a Gastroenterology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XENLETA 600MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for 1 month subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XGEVA 120MG/1.7ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XIFAXAN 550MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Prior Authorization required for quantities greater than 2 tablets per day. For quantities of 3 tablets per day, a diagnosis of IBS-D is required.

Products Affected

- XOLAIR 150MG INJ
- XOLAIR 150MG/ML PF INJ
- XOLAIR 75MG/0.5ML PF INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1. If for moderate to severe persistent asthma: There must be objective evidence of reversible airway obstruction AND the patient's lgE level must be between 30 IU/ml and 700 IU/ml (OR between 30 IU/mL and 1300 IU/mL for members aged 6 to 12 years) , AND the patient must have a positive skin test or RAST test for specific allergic sensitivity and one of the following: Inadequately controlled asthma despite medium dose of inhaled corticosteroids for at least 3 months in combination with a trial of long-acting inhaled beta-agonists OR a leukotriene modifier and systemic steroids OR high dose inhaled corticosteroids are required to maintain adequate asthma control OR intolerance or contradindication to the previously listed drugs. 2. If for chronic idiopathic urticaria, patient remains symptomatic despite H1 antihistamine treatment or has intolerance or contraindication to H1 antihistamine treatment.
Age Restrictions	If for moderate to severe persistent asthma, patient must be at least 6 years old. If for chronic idiopathic urticaria, patient must be at least 12 years old.
Prescriber Restriction	Prescribed by, or in consultation with an Allergy Specialist, Pulmonary Specialist, Dermatology Specialist or Immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XOSPATA 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of FLT3 mutation required.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- XPOVIO 100MG ONCE WEEKLY PACK (New Starts Only)
- XPOVIO 40MG TWICE WEEKLY PACK (New Starts Only)
- XPOVIO 60MG TWICE WEEKLY PACK (New Starts Only)
- XPOVIO 80MG TWICE WEEKLY PACK (New Starts Only)
- XPOVIO 40MG ONCE WEEKLY PACK (New Starts Only)
- XPOVIO 60MG ONCE WEEKLY PACK (New Starts Only)
- XPOVIO 80MG ONCE WEEKLY PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of prior therapies required. For multiple myeloma: prior therapies include at least 4 therapies, including at least 2 proteasome inhibitors, 2 immunomodulatory agents and an anti-CD38 monoclonal antibody. For diffuse large B-cell lymphoma: Trial of at least 2 lines of prior systemic therapy.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XTANDI 40MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic castration-resistant prostate cancer (mCRPC), failure of or intolerance to abiraterone (Zytiga equivalent) required. For nonmetastatic castration-resistant prostate cancer (nmCRPC), failure of or intolerance to apalutamide (Erleada) required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XULTOPHY 100UNIT-3.6MG/ML PEN INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is unable to achieve an A1c of 7 or under after three (3) months of treatment with a maximally dosed GLP-1 receptor agonist or basal insulin greater than or equal to thirty (30) units per day, OR member is currently using basal insulin AND a GLP-1 receptor agonist.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XYREM 500MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist, Pulmonologist, or Sleep Medicine Physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *miglustat 100mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Medical Geneticist, Hematologist, or Metabolic Physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZEJULA 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZELBORAF 240MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZOLINZA 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— ZYDELIG 100MG TAB (New Starts Only)

— ZYDELIG 150MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	DIAGNOSIS A: Patient has relapsed CLL, defined as CLL progression less than 24 months since the completion of the last prior therapy AND idelalisib (ZYDELIG) will be used in combination with rituximab (RITUXAN). DIAGNOSIS B and C: Patient has relapsed follicular B-cell non-Hodgkin lymphoma (FL) OR Patient has relapsed small lymphocytic lymphoma (SLL) AND Patient has received at least two (2) prior systemic therapies.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZYKADIA 150MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ANDRODERM 2MG/24HR PATCH
- TESTOSTERONE 1% GEL PUMP
- *testosterone 1% (50mg) gel*
- *testosterone 1.62% (1.25gm) gel*
- ANDRODERM 4MG/24HR PATCH
- *testosterone 1% (25mg) gel*
- *testosterone 1.62% gel pump*
- *testosterone 1.62% (2.5gm) gel*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two morning testosterone levels fall below the normal range for a healthy adult male. For patients on testosterone replacement therapy, documentation of at least one (1) morning testosterone level from the last 12 months is required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *glyburide 1.25mg/metformin 250mg tab*
— *glyburide 2.5mg/metformin 500mg tab*
— *glyburide 5mg/metformin 500mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Prior Authorization applies to patients 65 years or older.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	If prescribed for diabetes (sulfonylurea), trial or intolerance to ONE of the following: glipizide or glimepiride.

Products Affected

— DOPTELET 40MG DAILY DOSE PACK

— DOPTELET 60MG DAILY DOSE PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has a platelet count from the prior two weeks that shows less than 50,000 platelets per microliter.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

— *zolpidem tartrate 10mg tab*

— *zolpidem tartrate 5mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial or intolerance to ONE Non-High Risk formulary alternative: Trazodone or Mirtazapine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Health Pointe Direct Complete Plan (HMO I-SNP) is required by federal law to provide the following information.

Health Pointe Direct Complete Plan (HMO I-SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Health Pointe Direct Complete Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Pointe Direct Complete Plan provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Health Pointe Direct Complete Plan provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the Member Services at 1-888-201-4342.

If you believe that Health Pointe Direct Complete Plan (HMO I-SNP) has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. If you need help filing a grievance, The Grievance Department is available to help you. You can file a grievance in person or by mail, fax, or email:

Grievance Department
810 7th Ave, Suite 801
New York, NY 10019
Phone: 1-888-201-4342
Email: Grievance@healthpointeny.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Health Pointe of New York

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-201-4342 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-201-4342 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电1-888-201-4342 (TTY 711). 我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電1-888-201-4342 (TTY 711). 我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-201-4342 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-201-4342 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-201-4342 (TTY 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-201-4342 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화1-888-201-4342 (TTY 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-201-4342 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على24341028881. سيقوم شخص ما يتحدث بمساعدتك. هذه خدمة مجانية العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-201-4342 (TTY 711). पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-201-4342 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-201-4342 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-201-4342 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-201-4342 (TTY 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-201-4342 (TTY 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。