Baylor Scott & White Health Plan

BSW SeniorCare Advantage Select Rx (HMO-POS)
BSW SeniorCare Advantage Preferred Rx (HMO-POS)
BSW SeniorCare Advantage Premium Rx (HMO-POS)
BSW SeniorCare Advantage (PPO)
BSW SeniorCare Advantage Basic (PPO)
BSW SeniorCare Advantage Platinum (PPO)

2027 Prior Authorization Criteria

2027 PRIOR AUTHORIZATION CRITERIA

TABLE OF CONTENTS

A

Abiraterone Acetate 356
Abirtega 356
Accutane 150
Acitretin 10
Actimmune 11
Acyclovir Oint 12
Adempas 211
Aimovig 13
Akeega 231
Alcohol Swabs 14
Alecensa 232
Alosetron Hcl 15
Alprazolam 69
Alunbrig 233
Ambrisentan 212
Amnesteem 150
Aranesp Albumin Free 121
Arcalyst 59
Arikayce 60
Aripiprazole Odt 20
Aripiprazole Sol 21
Aripiprazole Tab 22
Armodafinil 61
Asenapine Maleate Sl 23
Atovaquone 64
Augtyro 234
Austedo 65
Austedo Xr 65
Austedo Xr Patient Titration Kit 65
Avmapki Fakzynja Co-Pack 235
Avonex 176
Avonex Pen 176
Ayvakit 236

B

Balversa 237
Belsomra 66
Benlysta 68
Benztropine Mesylate 137
Besremi 238
Betaseron 177
Bexarotene Cap 326
Bexarotene Gel 77

Bildyos....78
Bilprevda....79
Bonsity....367
Bosulif Cap....239
Bosulif Tab....240
Bosutinib Tab....240
Braftovi....241
Brukinsa....242
Budesonide Dr (Entocort)....95
Budesonide Er (Uceris)....96
Buprenorphine....195
Bysanti....24

C

Cabometyx....243
Calquence....244
Caprelsa....245
Carglumic Acid....97
Cavhanza....246
Cayston....98
Chlorpromazine Sol....25
Chlorpromazine Tab....26
Cinacalcet Hcl....99
Claravis....150
Clobazam....70
Clorazepate Dipotassium....71
Clozapine....28
Clozapine Odt....27
Cobenfy....100
Cobenfy Starter Pack....100
Cometriq....247
Copiktra....248
Cosentyx....81
Cosentyx Sensoready Pen....81
Cosentyx Unoready....81
Cotellic....249
Cresemba....107
Ctexli....108
Cystagon....110
Cystaran....109

D

Dalfampridine Er....111
Danazol....17
Danziten....250
Dasatinib....318
Daurismo....251
Dayvigo....112
Deferasirox (Exjade)....148
Deferasirox (Jadenu)....149
Depo-Testosterone....18
Dexmethylphenidate Hcl (Focalin)....129
Diacomit....113
Diazepam....72
Diazepam Intensol....72

Diclofenac Sodium (Pennsaid) 373
Diclofenac Sodium Gel 3% 372
Dicyclomine Hcl 138
Dihydroergotamine Mesylate 173
Dimethyl Fumarate 178
Dimethyl Fumarate Starterpack 178
Diphenoxylate/Atropine 140
Droxidopa 114
Dupixent 115

E

Eligard 116
Eltrombopag Olamine 117
Emgality 118
Emsam 119
Enbrel 82
Enbrel Mini 82
Enbrel Sureclick 82
Ensacove 252
Entyvio Pen 83
Epidiolex 120
Erivedge 253
Erleada 254
Erlotinib Hcl 325
Eucrisa 62
Everolimus Tab 229
Everolimus Tab (for Oral Susp) 230
Eysuvis 123

F

Fanapt 29
Fasenra 124
Fasenra Pen 124
Fentanyl 197
Filspari 126
Fingolimod Hcl 179
Fintepla 127
Firmagon 145
Flucytosine 128
Fluphenazine Decanoate 31
Fluphenazine Hcl (Elixer) 30
Fluphenazine Hcl (Inj) 31
Fluphenazine Hcl (Sol) 32
Fluphenazine Hcl (Tab) 33
Fotivda 255
Fruzaqla 256
Fulphila 101
Fylnetra 102

G

Gammagard Liquid 130
Gammagard Liquid Erc 131
Gamunex-C 132
Gauze Pads 133
Gavreto 257

Gefitinib 273
Gilotrif 258
Glatiramer Acetate 180
Glatopa 180
Gomekli 260

H

Hadlima 84
Hadlima Pushtouch 84
Haegarda 135
Haloperidol Decanoate Inj 34
Haloperidol Lactate Inj 34
Haloperidol Sol 35
Haloperidol Tab 36
Hernexeos 261
Hydroxyzine Hcl 139
Hydroxyzine Pamoate 139
Hyrnuo 262

I

Ibrance 263
Ibtrozi 264
Icatibant Acetate 136
Iclusig 265
Idhifa 266
Imatinib Mesylate 259
Imbruvica 267
Imiquimod Cream 5% 143
Imkeldi 268
Inbrija 144
Inluriyo 269
Inlyta 270
Inqovi 271
Inrebic 272
Insulin Pen Needle 146
Insulin Syringe/Needle 147
Isotretinoin 150
Itovebi 274
Ivabradine Hcl 106
Ivermectin Cream 151
Ivermectin Tab 152
Iwilfin 275

J

Jakafi 276
Jaypirca 277

K

Kalydeco 154
Kerendia 155
Kesimpta 181
Kisqali 278
Komzifti 279
Koselugo 280
Krazati 281

L

Lapatinib Ditosylate 335
Lazcluze 282
Lenalidomide 310
Lenvima 283
Leukine 103
Leuprolide Acetate (Lupron) 163
Leuprolide Acetate (Lutrate Depot) 164
L-Glutamine 156
Lidocaine Ointment 157
Lidocaine Patch 158
Lidocaine Solution 159
Lidocaine/Prilocaine 160
Lidocan 158
Lifyorli 284
Lonsurf 285
Lorazepam 73
Lorazepam Intensol 73
Lorbrena 286
Loxapine 37
Lumakras 287
Lupron Depot (1-Month) 161
Lupron Depot-Ped (1-Month) 162
Lupron Depot-Ped (3-Month) 162
Lupron Depot-Ped (6-Month) 162
Lurasidone Hcl 38
Lybalvi 39
Lynparza 288
Lytgobi 289

M

Matulane 290
Mavyret 165
Mekinist 291
Mektovi 292
Memantine Hcl 167
Memantine Hcl Er 166
Memantine Hcl Titration Pak 167
Methylphenidate Hcl (Methylin) 168
Methylphenidate Hcl (Ritalin) 224
Methylphenidate Hcl Er Tablet 169
Metyrosine 170
Miebo 171
Mifepristone 172
Modafinil 174
Modeyso 293
Molindone Hcl 40
Morphine Sulfate Er 199
Mounjaro 175

N

Nayzilam 74
Nerlynx 294
Nexletol 184

Nexlizet 185
Nilotinib 327
Ninlaro 296
Nintedanib Esylate 186
Nitisinone 187
Nivestym 104
Nubeqa 297
Nucala 188
Nuedexta 190
Nuplazid 191
Nurtec 192

O

Octreotide Acetate 363
Odomzo 298
Ofev 186
Ogsiveo 299
Ojemda 300
Ojjaara 301
Olanzapine Inj 41
Olanzapine Odt 42
Olanzapine Tab 43
Omnipod Go 193
Omnipod Kit 193
Omnipod Pods 193
Omnitrope 134
Onureg 302
Opipza 44
Orenitram 213
Orenitram Titration Kit 213
Orgovyx 303
Orserdu 304
Otezla 203
Otezla Xr 204
Ozempic Inj 205
Ozempic Tab 206

P

Paliperidone Er 45
Panretin 207
Pazopanib Hcl 344
Pegasys 208
Pemazyre 305
Perphenazine 46
Pimozide 47
Piqray 306
Pirfenidone 209
Plegridy 182
Plegridy Starter Pack 182
Pomalidomide 307
Pomalyst 307
Posaconazole Dr 210
Prolastin-C 16
Pyrimethamine 217
Pyrukynd 218

Pyrukynd Taper Pack 218
Pyzchiva 85

Q

Qinlock 308
Quetiapine Fumarate 48
Quetiapine Fumarate Er 49
Quinine Sulfate 219

R

Repatha 220
Repatha Sureclick 220
Retacrit 122
Retevmo 309
Revcovi 221
Revuforj 311
Rexulti 50
Rezdiffra 222
Rezlidhia 312
Rezurock 223
Rinvoq Lq 86
Rinvoq Tab 87
Risperidone Odt 51
Risperidone Sol 52
Roflumilast 225
Romvimza 313
Rozlytrek 314
Rubraca 315
Rufinamide 226
Rybelsus 227
Rydapt 316

S

Sapropterin Dihydrochloride 228
Scemblix 317
Scopolamine 141
Secuado 53
Signifor 357
Sildenafil Citrate 214
Simlandi 88
Sirturo 358
Sivextro 359
Skyrizi 89
Skyrizi Pen 89
Sodium Oxybate 361
Sodium Phenylbutyrate 381
Somavert 364
Sorafenib 295
Stivarga 319
Sunitinib Malate 320
Sympazan 75

T

Tabrecta 321
Tacrolimus 63

Tadalafil Tablet 2.5Mg; 5Mg 67
Tadalafil Tablet 20Mg 215
Tafinlar 322
Tagrisso 323
Talzenna 324
Tarpeyo 365
Tasimelteon 366
Tazarotene 374
Tepmetko 328
Teriparatide 367
Testosterone Cypionate 18
Testosterone Enanthate 19
Testosterone Gel 368
Testosterone Pump 368
Tetrabenazine 369
Thalomid 329
Thioridazine Hcl 54
Thiothixene 55
Tibsovo 330
Tobi Podhaler 370
Tobramycin Neb 371
Tolvaptan (Jynarque) 153
Torpenz 229
Tramadol Hcl Er 201
Trelstar Mixject 376
Tremfya 90
Tretinoin (Topical) 375
Tretinoin Cap 331
Tridacaine 158
Trientine Hcl 377
Trifluoperazine Hcl 56
Trihexyphenidyl Hcl 142
Trikafta 378
Trulicity 379
Truqap 332
Tukysa 333
Turalio 334
Tyenne 91
Tymlos 380

V

Valchlor 382
Valtoco 76
Vanflyta 336
Velsipity 92
Venclexta 337
Veozah 383
Veppanu 338
Versacloz 57
Verzenio 339
Vitrakvi 340
Vizimpro 341
Vonjo 342
Voranigo 343
Voriconazole 384

Vosevi 385
Vowst 386
Vumerity 183

W

Wegovy Inj 387
Wegovy Tab 388
Welireg 345
Winrevair 216

X

Xalkori 346
Xdemvy 389
Xermelo 390
Xifaxan 200Mg 391
Xifaxan 550Mg 392
Xiidra 194
Xolair 393
Xospata 347
Xpovio 348
Xtandi 349

Y

Yesintek 93
Yonsa 350
Yulithira 229

Z

Zarxio 105
Zejula 351
Zelboraf 352
Zenatane 150
Ziprasidone Mesylate 58
Zokinvy 396
Zolinza 353
Ztalmy 397
Zydelig 354
Zykadia 355
Zymfentra 94

Prior Authorization Group Description:
Acitretin PA
Drug Name(s)
Acitretin
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. BOTH of the following:
        i. Patient has a diagnosis of severe psoriasis AND
        ii. ONE of the following:
            1. Patient has tried and had an inadequate response to BOTH methotrexate and cyclosporine OR
            2. Patient has an intolerance or hypersensitivity to BOTH methotrexate and cyclosporine OR
            3. Patient has an FDA labeled contraindication to BOTH methotrexate and cyclosporine OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of severe psoriasis OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Actimmune PA
Drug Name(s)
Actimmune
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Acyclovir Ointment PA
Drug Name(s)
Acyclovir Oint
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Aimovig PA
Drug Name(s)
Aimovig
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Alcohol Swabs PA
Drug Name(s)
Alcohol Swabs
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
This program will be implemented as a dynamic PA.
Criteria for approval require BOTH of the following:
1. The requested medical supply product will be used in the delivery of insulin to the body AND
2. Patient's medication history includes use of insulin within the past 180 days
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Alosetron PA
Drug Name(s)
Alosetron Hcl
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS-D) AND
2. Patient's sex is female AND
3. Patient exhibits at least ONE of the following:
    a. Frequent and severe abdominal pain/discomfort OR
    b. Frequent bowel urgency or fecal incontinence OR
    c. Disability or restriction of daily activities due to IBS AND
4. Prescriber has ruled out anatomic or biochemical abnormalities of the gastrointestinal tract
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Alpha-1-Proteinase Inhibitor PA - Prolastin-C
Drug Name(s)
Prolastin-C
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Anabolic Steroid PA - Danazol
Drug Name(s)
Danazol
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has ONE of the following diagnoses:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. Patient will NOT be using the requested agent in combination with another androgen or anabolic steroid OR
    B. Prescriber has provided information in support of therapy with more than one agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Androgen Injectable PA - testosterone cypionate
Drug Name(s)
Depo-Testosterone
Testosterone Cypionate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Androgen Injectable PA - testosterone enanthate
Drug Name(s)
Testosterone Enanthate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Aripiprazole ODT
Drug Name(s)
Aripiprazole Odt
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Aripiprazole Solution
Drug Name(s)
Aripiprazole Sol
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Aripiprazole Tablet
Drug Name(s)
Aripiprazole Tab
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Asenapine Tablet
Drug Name(s)
Asenapine Maleate Sl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Bysanti
Drug Name(s)
Bysanti
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Chlorpromazine Solution
Drug Name(s)
Chlorpromazine Sol
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Chlorpromazine Tablet
Drug Name(s)
Chlorpromazine Tab
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Clozapine ODT
Drug Name(s)
Clozapine Odt
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Clozapine Tablet
Drug Name(s)
Clozapine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Fanapt
Drug Name(s)
Fanapt
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Fluphenazine Elixir
Drug Name(s)
Fluphenazine Hcl (Elixer)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Fluphenazine Inj
Drug Name(s)
Fluphenazine Decanoate
Fluphenazine Hcl (Inj)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Fluphenazine Solution
Drug Name(s)
Fluphenazine Hcl (Sol)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Fluphenazine Tablet
Drug Name(s)
Fluphenazine Hcl (Tab)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Haloperidol Inj
Drug Name(s)
Haloperidol Decanoate Inj
Haloperidol Lactate Inj
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Haloperidol Solution
Drug Name(s)
Haloperidol Sol
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Haloperidol Tablet
Drug Name(s)
Haloperidol Tab
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Loxapine
Drug Name(s)
Loxapine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Lurasidone
Drug Name(s)
Lurasidone Hcl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Lybalvi
Drug Name(s)
Lybalvi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Molindone
Drug Name(s)
Molindone Hcl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Olanzapine Inj
Drug Name(s)
Olanzapine Inj
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Olanzapine ODT
Drug Name(s)
Olanzapine Odt
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Olanzapine Tablet
Drug Name(s)
Olanzapine Tab
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Opipza
Drug Name(s)
Opipza
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Paliperidone Tablet
Drug Name(s)
Paliperidone Er
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Perphenazine
Drug Name(s)
Perphenazine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Pimozide
Drug Name(s)
Pimozide
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Quetiapine
Drug Name(s)
Quetiapine Fumarate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Quetiapine ER
Drug Name(s)
Quetiapine Fumarate Er
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Rexulti
Drug Name(s)
Rexulti
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Risperidone ODT
Drug Name(s)
Risperidone Odt
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Risperidone Solution
Drug Name(s)
Risperidone Sol
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Secuado
Drug Name(s)
Secuado
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Thioridazine
Drug Name(s)
Thioridazine Hcl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Thiothixene
Drug Name(s)
Thiothixene
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Trifluoperazine
Drug Name(s)
Trifluoperazine Hcl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Antipsychotics PA - Versacloz
Drug Name(s)
Versacloz
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    b. Prescriber states the patient is currently being treated with the requested agent OR
    c. ONE of the following:
        i. Patient has a diagnosis other than dementia-related psychosis or dementia-related behavioral symptoms OR
        ii. Patient has dementia-related psychosis or dementia-related behavioral symptoms AND BOTH of the following:
            1. Dementia-related psychosis is determined to be severe or the associated behavior puts the patient or others in danger AND
            2. Prescriber has discussed the risk of increased mortality with the patient and/or the patient's surrogate decision maker

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Antipsychotics PA - Ziprasidone Inj
Drug Name(s)
Ziprasidone Mesylate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Arcalyst PA
Drug Name(s)
Arcalyst
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has been diagnosed with Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Auto-inflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS) OR
    B. BOTH of the following:
        i. Patient has a diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA) AND
        ii. The requested agent is being used for maintenance of remission OR
    C. BOTH of the following:
        i. Patient has a diagnosis of recurrent pericarditis AND
        ii. The requested agent is being used to reduce the risk of recurrence AND
2. Patient will NOT be using the requested agent in combination with another biologic agent
Age Restriction:
For diagnosis of CAPS including FCAS or MWS, patient is 12 years of age or over.

For diagnosis of recurrent pericarditis and reduction in risk of recurrence, patient is 12 years of age or over.
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Arikayce PA
Drug Name(s)
Arikayce
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Armodafinil PA
Drug Name(s)
Armodafinil
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of excessive sleepiness associated with narcolepsy as confirmed by a sleep study OR
    B. Patient has a diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA) as confirmed by a sleep study OR
    C. Patient has another FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another target agent (i.e., modafinil)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of excessive sleepiness associated with narcolepsy OR
    B. Patient has a diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA) OR
    C. Patient has another FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another target agent (i.e., modafinil)
Age Restriction:
Patient is 18 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Atopic Dermatitis PA - Eucrisa
Drug Name(s)
Eucrisa
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of atopic dermatitis AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to a topical corticosteroid or topical corticosteroid combination preparation (e.g., hydrocortisone, triamcinolone) OR
    B. Patient has an intolerance or hypersensitivity to a topical corticosteroid or topical corticosteroid combination preparation OR
    C. Patient has an FDA labeled contraindication to a topical corticosteroid or topical corticosteroid combination preparation
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Atopic Dermatitis PA - Tacrolimus
Drug Name(s)
Tacrolimus
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of atopic dermatitis AND ONE of the following:
        i. Patient has tried and had an inadequate response to a topical corticosteroid or topical corticosteroid combination preparation (e.g., hydrocortisone, triamcinolone) OR
        ii. Patient has an intolerance or hypersensitivity to a topical corticosteroid or topical corticosteroid combination preparation OR
        iii. Patient has an FDA labeled contraindication to a topical corticosteroid or topical corticosteroid combination preparation OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Atovaquone PA
Drug Name(s)
Atovaquone
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            1. Patient has a diagnosis of mild-to-moderate Pneumocystis jirovecii pneumonia OR
            2. Patient is using the requested agent for prevention of Pneumocystis jirovecii pneumonia AND
        ii. ONE of the following:
            1. Patient has an intolerance or hypersensitivity to trimethoprim/sulfamethoxazole (TMP/SMX) OR
            2. Patient has an FDA labeled contraindication to trimethoprim/sulfamethoxazole (TMP/SMX) OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Austedo PA
Drug Name(s)
Austedo
Austedo Xr
Austedo Xr Patient Titration Kit
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Belsomra PA
Drug Name(s)
Belsomra
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Benign Prostatic Hyperplasia PA - Tadalafil
Drug Name(s)
Tadalafil Tablet 2.5Mg; 5Mg
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used to treat erectile dysfunction ONLY AND FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient is using the requested agent for a diagnosis of benign prostatic hyperplasia (BPH) AND
2. Patient has tried and had an insufficient response, intolerance or hypersensitivity, or FDA labeled contraindication to TWO alpha blocker agents (e.g., terazosin, doxazosin, tamsulosin)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Benlysta SC PA
Drug Name(s)
Benlysta
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Benzodiazepines PA - Alprazolam
Drug Name(s)
Alprazolam
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            a. Anxiety disorder or panic disorder AND ONE of the following:
                1) Patient has tried and had an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
                2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR
                3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR
            b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Benzodiazepines PA - Clobazam
Drug Name(s)
Clobazam
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            a. Seizure disorder OR
            b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Benzodiazepines PA - Clorazepate
Drug Name(s)
Clorazepate Dipotassium
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            a. Seizure disorder OR
            b. Anxiety disorder AND ONE of the following:
                1) Patient has tried and has an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
                2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR
                3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR
            c. Alcohol withdrawal OR
            d. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Benzodiazepines PA - Diazepam
Drug Name(s)
Diazepam
Diazepam Intensol
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            a. Seizure disorder OR
            b. Anxiety disorder AND ONE of the following:
                1) Patient has tried and had an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
                2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR
                3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR
            c. Skeletal muscle spasms OR
            d. Alcohol withdrawal OR
            e. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Benzodiazepines PA - Lorazepam
Drug Name(s)
Lorazepam
Lorazepam Intensol
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            a. Anxiety disorder AND ONE of the following:
                1) Patient has tried and had an inadequate response to a formulary selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) OR
                2) Patient has an intolerance or hypersensitivity to a formulary SSRI or SNRI OR
                3) Patient has an FDA labeled contraindication to a formulary SSRI or SNRI OR
            b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Benzodiazepines PA - Nayzilam
Drug Name(s)
Nayzilam
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Benzodiazepines PA - Sympazan
Drug Name(s)
Sympazan
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has ONE of the following diagnoses:
            a. Seizure disorder OR
            b. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Benzodiazepines PA - Valtoco
Drug Name(s)
Valtoco
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. ONE of the following:
            a. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
            b. Prescriber states the patient is currently being treated with the requested agent AND
        ii. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent OR
    B. BOTH of the following:
        i. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Bexarotene Gel PA
Drug Name(s)
Bexarotene Gel
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Bildyos PA
Drug Name(s)
Bildyos
Indications:
All FDA-Approved Indications, Some Medically-Accepted Indications.
Off-Label Uses:
Osteopenia (osteoporosis prophylaxis)
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Bilprevda PA
Drug Name(s)
Bilprevda
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of multiple myeloma AND BOTH of the following:
        i. The requested agent will be used for the prevention of skeletal-related events AND
        ii. ONE of the following:
            1. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR
            2. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR
            3. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR
    B. Patient has a diagnosis of prostate cancer AND ALL of the following:
        i. The requested agent will be used for the prevention of skeletal-related events AND
        ii. Patient has bone metastases AND
        iii. ONE of the following:
            1. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR
            2. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR
            3. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR

Criteria continues: see Other Criteria
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
    C. Patient has a solid tumor cancer diagnosis (e.g., thyroid, non-small cell lung, kidney cancer, or breast cancer) AND ALL of the following:
        i. The requested agent will be used for the prevention of skeletal-related events AND
        ii. Patient has bone metastases AND
        iii. ONE of the following:
            1. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR

2. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR

3. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR

D. Patient has a diagnosis of giant cell tumor of bone AND ONE of the following:

i. Patient has a pretreatment or current calcium level that is NOT below the limits of the testing laboratory's normal range OR

ii. Patient has a pretreatment or current calcium level that is below the limits of the testing laboratory's normal range AND it will be corrected prior to use of the requested agent OR

iii. Prescriber has indicated that the patient is not at risk for hypocalcemia (not including risk associated with the requested agent) OR

E. Patient has a diagnosis of hypercalcemia of malignancy AND

2. Patient will NOT be using the requested agent in combination with another form of denosumab

Part B Prerequisite:

No

Prerequisite Therapy Required:

No

Prior Authorization Group Description:
Biologic Immunomodulators PA - Cosentyx
Drug Name(s)
Cosentyx
Cosentyx Sensoready Pen
Cosentyx Unoready
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Enbrel
Drug Name(s)
Enbrel
Enbrel Mini
Enbrel Sureclick
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Entyvio SC
Drug Name(s)
Entyvio Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Hadlima
Drug Name(s)
Hadlima
Hadlima Pushtouch
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Pyzchiva
Drug Name(s)
Pyzchiva
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Rinvoq Solution
Drug Name(s)
Rinvoq Lq
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
    B. Prescriber states the patient is currently being treated with the requested agent AND provided clinical justification to support that the patient is at risk if therapy is changed OR
    C. ONE of the following:
        i. Patient's medication history indicates use of preferred TNF agent(s) OR
        ii. Patient has an intolerance or hypersensitivity to preferred TNF agent(s) OR
        iii. Patient has an FDA labeled contraindication to preferred TNF agent(s) OR
        iv. The request is for an FDA labeled indication that is not covered by preferred TNF agent(s) AND
3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND
4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Use of ONE preferred TNF (Hadlima or Simlandi) is required for diagnoses of adult psoriatic arthritis or juvenile idiopathic arthritis

NO preferred TNF agent is required for diagnosis of pediatric psoriatic arthritis
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Biologic Immunomodulators PA - Rinvoq Tablet
Drug Name(s)
Rinvoq Tab
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Simlandi
Drug Name(s)
Simlandi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Skyrizi
Drug Name(s)
Skyrizi
Skyrizi Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Tremfya
Drug Name(s)
Tremfya
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Tyenne
Drug Name(s)
Tyenne
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Velsipity
Drug Name(s)
Velsipity
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Yesintek
Drug Name(s)
Yesintek
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Biologic Immunomodulators PA - Zymfentra
Drug Name(s)
Zymfentra
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Budesonide Oral ER PA - Entocort
Drug Name(s)
Budesonide Dr (Entocort)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Budesonide Oral ER PA - Uceris
Drug Name(s)
Budesonide Er (Uceris)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Carglumic PA
Drug Name(s)
Carglumic Acid
Indications:
All FDA-Approved Indications, Some Medically-Accepted Indications.
Off-Label Uses:
Acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA)
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has a diagnosis of ONE of the following:
    a. Acute hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) OR
    b. Chronic hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) OR
    c. Acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) AND
2. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist, nephrologist, metabolic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Cayston PA
Drug Name(s)
Cayston
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. Documentation has been provided that indicates the patient has a Pseudomonas aeruginosa respiratory infection AND
3. ONE of the following:
    a. Patient is NOT currently (within the past 56 days) being treated with another inhaled antibiotic (e.g., inhaled tobramycin) OR
    b. Patient is currently (within the past 56 days) being treated with another inhaled antibiotic (e.g., inhaled tobramycin) AND ONE of the following:
        i. Prescriber has confirmed that the other inhaled antibiotic will be discontinued, and that therapy will be continued only with the requested agent OR
        ii. Prescriber has provided information in support of another inhaled antibiotic therapy used concurrently with or alternating with (i.e., continuous alternating therapy) the requested agent

Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Cinacalcet PA
Drug Name(s)
Cinacalcet Hcl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has ONE of the following:
    A. A diagnosis of hypercalcemia due to parathyroid carcinoma OR
    B. A diagnosis of primary hyperparathyroidism (HPT) AND BOTH of the following:
        i. Patient has a pretreatment serum calcium level that is above the testing laboratory's upper limit of normal AND
        ii. Patient is unable to undergo parathyroidectomy OR
    C. Another indication that is FDA approved or supported in CMS approved compendia for the requested agent not otherwise excluded from Part D [i.e., secondary hyperparathyroidism due to end-stage renal disease (ESRD) on dialysis]
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Cobenfy PA
Drug Name(s)
Cobenfy
Cobenfy Starter Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Colony Stimulating Factors PA - Fulphila
Drug Name(s)
Fulphila
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Colony Stimulating Factors PA - Fylnetra
Drug Name(s)
Fylnetra
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Colony Stimulating Factors PA - Leukine
Drug Name(s)
Leukine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Colony Stimulating Factors PA - Nivestym
Drug Name(s)
Nivestym
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Colony Stimulating Factors PA - Zarxio
Drug Name(s)
Zarxio
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 6 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Corlanor PA
Drug Name(s)
Ivabradine Hcl
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of following:
    A. ALL of the following:
        i. Patient has stable, symptomatic heart failure (e.g., NYHA Class II, III, IV: ACCF/AHA Class C, D) due to dilated cardiomyopathy (DCM) AND
        ii. The requested agent is for a pediatric patient, 6 months of age or over AND
        iii. Patient is in sinus rhythm with an elevated heart rate OR
    B. ALL of the following:
        i. Patient has stable, symptomatic chronic heart failure (e.g., NYHA Class II, III, IV: ACCF/AHA Class C, D) AND
        ii. The requested agent is for an adult patient AND
        iii. Patient has a baseline OR current left ventricular ejection fraction of 35% or less AND
        iv. Patient is in sinus rhythm with a resting heart rate of 70 beats or greater per minute prior to initiating therapy with the requested agent AND
        v. ONE of the following:
            a. Patient is on a maximally tolerated dose of a beta blocker (e.g., bisoprolol, carvedilol, metoprolol) OR
            b. Patient has an intolerance, FDA labeled contraindications, or hypersensitivity to a beta blocker
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Cresemba PA
Drug Name(s)
Cresemba
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of invasive aspergillosis OR
    B. Patient has a diagnosis of invasive mucormycosis OR
    C. Patient has another indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of invasive aspergillosis or invasive mucormycosis and patient has continued indicators of active disease (e.g., biomarkers in serum assay, microbiologic culture, radiographic evidence) OR
    B. BOTH of the following:
        i. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 6 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Ctexli PA
Drug Name(s)
Ctexli
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require the following:
1. Patient has a diagnosis of cerebrotendinous xanthomatosis (CTX) as confirmed by ONE of the following:
    A. Genetic testing confirming variants in the CYP27A1 gene OR
    B. ALL of the following:
        i. Elevated plasma cholestanol greater than or equal to 5 to 10 times ULN (upper limit of normal) AND
        ii. Urine positive for bile alcohols AND
        iii. Clinical findings consistent for CTX (e.g., xanthomas [present in lungs, tendons, bone or central nervous system], infantile-onset diarrhea, childhood-onset cataract(s), adult-onset progressive neurologic dysfunction [dementia, psychiatric disturbances, pyramidal and/or cerebellar signs, dystonia, atypical parkinsonism, peripheral neuropathy, and seizures])

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of cerebrotendinous xanthomatosis (CTX) AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, gastroenterologist, hepatologist, neurologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Cystaran PA
Drug Name(s)
Cystaran
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., ophthalmologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Cystinosis Agents PA - Cystagon
Drug Name(s)
Cystagon
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of nephropathic cystinosis AND
2. Prescriber has performed a baseline white blood cell (WBC) cystine level test AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of nephropathic cystinosis AND
3. Patient has had clinical benefit with the requested agent (e.g., decrease in WBC cystine levels from baseline) AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Dalfampridine PA
Drug Name(s)
Dalfampridine Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. Patient has a diagnosis of multiple sclerosis (MS)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of multiple sclerosis (MS) AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Dayvigo PA
Drug Name(s)
Dayvigo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Diacomit PA
Drug Name(s)
Diacomit
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Droxidopa PA
Drug Name(s)
Droxidopa
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Dupixent PA
Drug Name(s)
Dupixent
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Eligard PA
Drug Name(s)
Eligard
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. BOTH of the following:
        i. Patient is NOT currently being treated with the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Eltrombopag PA
Drug Name(s)
Eltrombopag Olamine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Emgality PA
Drug Name(s)
Emgality
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Emsam PA
Drug Name(s)
Emsam
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Epidiolex PA
Drug Name(s)
Epidiolex
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Erythropoietin Stimulating Agents PA - Aranesp
Drug Name(s)
Aranesp Albumin Free
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Erythropoietin Stimulating Agents PA - Retacrit
Drug Name(s)
Retacrit
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Eysuvis PA
Drug Name(s)
Eysuvis
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of dry eye disease AND
2. The requested agent will be used for short-term (up to two weeks) treatment AND
3. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 1 month
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Fasenra PA
Drug Name(s)
Fasenra
Fasenra Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of severe asthma with an eosinophilic phenotype AND the following:
        i. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent OR
    B. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the following:
        i. ONE of the following:
            a. Patient is currently being treated with a maximally tolerated oral corticosteroid OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an oral corticosteroid OR
    C. Patient has a diagnosis of hypereosinophilic syndrome (HES) without an identifiable non-hematologic secondary cause AND the following:
        i. ONE of the following:
            a. Patient is currently being treated with a maximally tolerated oral corticosteroid OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an oral corticosteroid AND
2. Patient will NOT be using the requested agent in combination with Xolair, Dupixent, or with another injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Exdensur, Nucala) for the requested indication
Age Restriction:
For diagnosis of severe asthma with an eosinophilic phenotype, patient is 6 years of age or over. For diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA), patient is 18 years of age or over. For diagnosis of hypereosinophilic syndrome (HES) without an identifiable non-hematologic secondary cause, patient is 12 years of age or over.
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, otolaryngologist, pulmonologist, rheumatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:

A. Patient has a diagnosis of severe asthma with an eosinophilic phenotype AND the following:
i. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent OR
B. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the following:
i. ONE of the following:
a. Patient is currently being treated with maintenance therapy with oral corticosteroid OR
b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to oral corticosteroid OR
C. Patient has a diagnosis of hypereosinophilic syndrome (HES) without an identifiable non-hematologic secondary cause AND the following:
i. ONE of the following:
a. Patient is currently being treated with a maximally tolerated oral corticosteroid OR
b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an oral corticosteroid AND

3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with Xolair, Dupixent, or with another injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Exdensur, Nucala) for the requested indication

Part B Prerequisite:

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:
Filspari PA
Drug Name(s)
Filspari
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Fintepla PA
Drug Name(s)
Fintepla
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Flucytosine PA
Drug Name(s)
Flucytosine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. The requested agent will be used in combination with amphotericin B OR
    B. Prescriber has provided information in support of therapy without concurrent amphotericin B for the requested indication AND
3. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 10 weeks
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Focalin PA
Drug Name(s)
Dexmethylphenidate Hcl (Focalin)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Gammagard PA
Drug Name(s)
Gammagard Liquid
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Gammgd ERC PA
Drug Name(s)
Gammagard Liquid Erc
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Gamunex-C PA
Drug Name(s)
Gamunex-C
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Gauze Pads PA
Drug Name(s)
Gauze Pads
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
This program will be implemented as a dynamic PA.
Criteria for approval require BOTH of the following:
1. The requested medical supply product will be used in the delivery of insulin to the body AND
2. Patient's medication history includes use of insulin within the past 180 days
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Growth Hormone PA - Omnitrope
Drug Name(s)
Omnitrope
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
HAE PA - Haegarda
Drug Name(s)
Haegarda
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
HAE PA - Icatibant
Drug Name(s)
Icatibant Acetate
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
High Risk Medication PA - Benztropine
Drug Name(s)
Benztropine Mesylate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND
2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND
3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
High Risk Medication PA - Dicyclomine
Drug Name(s)
Dicyclomine Hcl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND
2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND
3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
High Risk Medication PA - Hydroxyzine
Drug Name(s)
Hydroxyzine Hcl
Hydroxyzine Pamoate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND
2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND
3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
High Risk Medication PA - Lomotil
Drug Name(s)
Diphenoxylate/Atropine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND
2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND
3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
High Risk Medication PA - Scopolamine
Drug Name(s)
Scopolamine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND
2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND
3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
High Risk Medication PA - Trihexyphenidyl
Drug Name(s)
Trihexyphenidyl Hcl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients less than 65 years of age.
Criteria for approval require ALL of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested high-risk medication AND
2. Prescriber has indicated that the benefits of the requested high-risk medication outweigh the risks for the patient AND
3. Prescriber has indicated that the risks and potential side effects of the requested high-risk medication have been discussed with the patient
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Imiquimod PA
Drug Name(s)
Imiquimod Cream 5%
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has ONE of the following diagnoses:
    A. Actinic keratosis OR
    B. Superficial basal cell carcinoma OR
    C. External genital and/or perianal warts/condyloma acuminata OR
    D. Squamous cell carcinoma OR
    E. Basal cell carcinoma OR
    F. Another indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
4 months for Actinic keratosis, other diagnoses - see Other Criteria
Other Criteria:
2 months for Superficial basal cell carcinoma, Squamous cell carcinoma, or Basal cell carcinoma

4 months for External genital and/or perianal warts/condyloma acuminata

12 months for All other diagnoses
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Inbrija PA
Drug Name(s)
Inbrija
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. The requested agent will be used for intermittent treatment of OFF episodes in patients with Parkinson's disease AND
2. The requested agent will be used in combination with carbidopa/levodopa
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Injectable Oncology PA - Firmagon
Drug Name(s)
Firmagon
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that is not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Insulin Pen Needle PA
Drug Name(s)
Insulin Pen Needle
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
This program will be implemented as a dynamic PA.
Criteria for approval require BOTH of the following:
1. The requested medical supply product will be used in the delivery of insulin to the body AND
2. Patient's medication history includes use of insulin within the past 180 days
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Insulin Syringe_Needle PA
Drug Name(s)
Insulin Syringe/Needle
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
This program will be implemented as a dynamic PA.
Criteria for approval require BOTH of the following:
1. The requested medical supply product will be used in the delivery of insulin to the body AND
2. Patient's medication history includes use of insulin within the past 180 days
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Iron Chelating Agents PA - Exjade
Drug Name(s)
Deferasirox (Exjade)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome AND ONE of the following:
        i. A liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight OR
        ii. A serum ferritin greater than 300 mcg/L OR
        iii. MRI confirmation of iron deposition OR
    B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND
2. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome OR
    B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent for the requested indication
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Iron Chelating Agents PA - Jadenu
Drug Name(s)
Deferasirox (Jadenu)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome AND ONE of the following:
        i. A liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight OR
        ii. A serum ferritin greater than 300 mcg/L OR
        iii. MRI confirmation of iron deposition OR
    B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND
2. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of chronic iron overload due to a non-transfusion dependent thalassemia syndrome OR
    B. Patient has a diagnosis of chronic iron overload due to blood transfusions AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another iron chelating agent (e.g., deferiprone) for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent for the requested indication
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Isotretinoin PA
Drug Name(s)
Accutane
Amnesteem
Claravis
Isotretinoin
Zenatane
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 months for initial, 12 months for renewal
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Ivermectin Cream PA
Drug Name(s)
Ivermectin Cream
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Ivermectin Tablet PA
Drug Name(s)
Ivermectin Tab
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 4 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Jynarque PA
Drug Name(s)
Tolvaptan (Jynarque)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed by ONE of the following:
    A. Ultrasound OR
    B. MRI or CT scan OR
    C. Genetic testing AND
2. Patient is at risk of rapid disease progression

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD) AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., nephrologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Kalydeco PA
Drug Name(s)
Kalydeco
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Kerendia PA
Drug Name(s)
Kerendia
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
L-glutamine PA
Drug Name(s)
L-Glutamine
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of sickle cell disease AND
2. Patient is using the requested agent to reduce the acute complications of sickle cell disease AND
3. ONE of the following:
    A. Patient has tried and had an inadequate response to maximally tolerated dose of hydroxyurea OR
    B. Patient has an intolerance or hypersensitivity to hydroxyurea OR
    C. Patient has an FDA labeled contraindication to hydroxyurea

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of sickle cell disease AND
3. Patient is using the requested agent to reduce the acute complications of sickle cell disease AND
4. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Lidocaine Topical PA - Lidocaine Ointment
Drug Name(s)
Lidocaine Ointment
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Lidocaine Topical PA - Lidocaine Patch
Drug Name(s)
Lidocaine Patch
Lidocan
Tridacaine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has ONE of the following diagnoses:
    A. Pain associated with postherpetic neuralgia (PHN) OR
    B. Pain associated with diabetic neuropathy OR
    C. Another diagnosis that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to a conventional therapy [e.g., gabapentin, pregabalin, oral prescription NSAID (non-steroidal anti-inflammatory drug)] for the requested indication OR
    B. Patient has an intolerance or hypersensitivity to a conventional therapy OR
    C. Patient has an FDA labeled contraindication to a conventional therapy
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Lidocaine Topical PA - Lidocaine Solution
Drug Name(s)
Lidocaine Solution
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. The requested agent will be used for ONE of the following:
    A. Topical anesthesia of accessible mucous membranes of the oral and nasal cavities OR
    B. Topical anesthesia of accessible mucous membranes of proximal portions of the digestive tract OR
    C. Another indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Lidocaine Topical PA - Lidocaine/prilocaine Cream
Drug Name(s)
Lidocaine/Prilocaine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. The requested agent will be used for ONE of the following:
    A. Local analgesia on normal intact skin OR
    B. Topical anesthetic for dermal procedures OR
    C. Adjunctive anesthesia prior to local anesthetic infiltration in adult male genital skin OR
    D. Anesthesia for minor procedures on female external genitalia OR
    E. Another indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Lupron Depot PA
Drug Name(s)
Lupron Depot (1-Month)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. BOTH of the following:
        i. Patient is NOT currently being treated with the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Lupron Depot Ped PA
Drug Name(s)
Lupron Depot-Ped (1-Month)
Lupron Depot-Ped (3-Month)
Lupron Depot-Ped (6-Month)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. BOTH of the following:
        i. Patient is NOT currently being treated with the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Lupron PA
Drug Name(s)
Leuprolide Acetate (Lupron)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. BOTH of the following:
        i. Patient is NOT currently being treated with the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Lutrate Depot PA
Drug Name(s)
Leuprolide Acetate (Lutrate Depot)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. BOTH of the following:
        i. Patient is NOT currently being treated with the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Mavyret PA
Drug Name(s)
Mavyret
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of hepatitis C confirmed by serological markers OR
    B. Patient is a hepatitis C virus (HCV) - uninfected solid organ transplant recipient AND BOTH of the following:
        i. Patient received an HCV - viremic donor organ AND
        ii. The requested agent is being used for prophylaxis AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The requested dose is within FDA labeled dosing or supported in AASLD/IDSA guideline dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Memantine ER PA
Drug Name(s)
Memantine Hcl Er
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients greater than or equal to 30 years of age
Criteria for approval require the following:
1. Patient is younger than 30 years of age AND ONE of the following:
    A. Patient has a diagnosis of moderate to severe dementia of the Alzheimer's type OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Memantine PA
Drug Name(s)
Memantine Hcl
Memantine Hcl Titration Pak
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
PA does NOT apply to patients greater than or equal to 30 years of age
Criteria for approval require the following:
1. Patient is younger than 30 years of age AND ONE of the following:
    A. Patient has a diagnosis of moderate to severe dementia of the Alzheimer's type OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Methylin PA
Drug Name(s)
Methylphenidate Hcl (Methylin)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Methylphenidate ER Tablet PA
Drug Name(s)
Methylphenidate Hcl Er Tablet
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Metyrosine PA
Drug Name(s)
Metyrosine
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, oncologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Miebo PA
Drug Name(s)
Miebo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Mifepristone PA
Drug Name(s)
Mifepristone
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of Cushing's syndrome AND
2. ONE of the following:
    A. Patient has type 2 diabetes mellitus OR
    B. Patient has glucose intolerance as defined by a 2-hour glucose tolerance test plasma glucose value of 140-199 mg/dL AND
3. ONE of the following:
    A. Patient had an inadequate response to surgical resection OR
    B. Patient is NOT a candidate for surgical resection

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Cushing's syndrome AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Migranal PA
Drug Name(s)
Dihydroergotamine Mesylate
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. The requested agent will be used for the treatment of acute migraine with or without aura AND
2. ONE of the following:
    A. Patient has tried and had an inadequate response to TWO triptan agents with differing active ingredients (e.g., sumatriptan, rizatriptan) OR
    B. Patient has an intolerance or hypersensitivity to a triptan agent OR
    C. Patient has an FDA labeled contraindication to a triptan agent AND
3. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, acute CGRP)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. The requested agent will be used for the treatment of acute migraine with or without aura AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, acute CGRP)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Modafinil PA
Drug Name(s)
Modafinil
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of excessive sleepiness associated with narcolepsy as confirmed by a sleep study OR
    B. Patient has a diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA) as confirmed by a sleep study OR
    C. Patient has another FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another target agent (i.e., armodafinil)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of excessive sleepiness associated with narcolepsy OR
    B. Patient has a diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA) OR
    C. Patient has another FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another target agent (i.e., armodafinil)
Age Restriction:
Patient is 18 years of age or over
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Mounjaro PA
Drug Name(s)
Mounjaro
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR
    C. ALL of the following:
        i. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND
        iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
MS PA - Avonex
Drug Name(s)
Avonex
Avonex Pen
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
MS PA - Betaseron
Drug Name(s)
Betaseron
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
MS PA - Dimethyl Fumarate
Drug Name(s)
Dimethyl Fumarate
Dimethyl Fumarate Starterpack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
MS PA - Fingolimod
Drug Name(s)
Fingolimod Hcl
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication AND
3. Prescriber will perform an electrocardiogram prior to initiating treatment

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
MS PA - Glatiramer
Drug Name(s)
Glatiramer Acetate
Glatopa
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
MS PA - Kesimpta
Drug Name(s)
Kesimpta
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
MS PA - Plegridy
Drug Name(s)
Plegridy
Plegridy Starter Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
MS PA - Vumerity
Drug Name(s)
Vumerity
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has an FDA labeled indication for the requested agent AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with another disease modifying therapy (DMT) or a biologic immunomodulator for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Nexletol PA
Drug Name(s)
Nexletol
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Nexlizet PA
Drug Name(s)
Nexlizet
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Nintedanib PA
Drug Name(s)
Nintedanib Esylate
Ofev
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Nitisinone PA
Drug Name(s)
Nitisinone
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of Hereditary Tyrosinemia Type 1 (HT-1) evidenced by ONE of the following:
    A. A confirmed laboratory detection of succinylacetone (SA) in urine or blood OR
    B. Genetic testing confirming biallelic pathogenic or likely pathogenic variants in the fumarylacetoacetate hydrolase (FAH) gene AND
2. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of Hereditary Tyrosinemia Type 1 (HT-1) AND
3. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, hepatologist, specialist in metabolic diseases) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Nucala PA
Drug Name(s)
Nucala
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. Patient has a diagnosis of severe asthma with an eosinophilic phenotype AND the following:
        i. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent OR
    B. Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype AND the following:
        i. Patient is currently being treated with AND will continue COPD control therapy (e.g., ICS, LABA, LAMA) in combination with the requested agent OR
    C. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the following:
        i. ONE of the following:
            a. Patient is currently being treated with a maximally tolerated oral corticosteroid OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an oral corticosteroid OR
    D. Patient has a diagnosis of hypereosinophilic syndrome (HES) for 6 months or more without an identifiable non-hematologic secondary cause AND the following:
        i. ONE of the following:
            a. Patient is currently being treated with a maximally tolerated oral corticosteroid OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an oral corticosteroid OR
    E. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND
2. Patient will NOT be using the requested agent in combination with Xolair, Dupixent, or with another injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Exdensur, Fasenra) for the requested indication
Age Restriction:
For diagnosis of severe asthma with an eosinophilic phenotype, patient is 6 years of age or over. For diagnosis of COPD and an eosinophilic phenotype, patient is 18 years of age or over. For diagnosis of EGPA, patient is 18 years of age or over. For diagnosis of HES, patient is 12 years of age or over. For diagnosis of CRSwNP, patient is 18 years of age or over.
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, otolaryngologist, pathologist, pulmonologist, rheumatologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Criteria for renewal approval require ALL of the following:

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of severe asthma with an eosinophilic phenotype AND the following:
        i. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent OR
    B. Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype AND the following:
        i. Patient is currently being treated with AND will continue COPD control therapy (e.g., ICS, LABA, LAMA) in combination with the requested agent OR
    C. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the following:
        i. ONE of the following:
            a. Patient is currently being treated with maintenance therapy with oral corticosteroid OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to oral corticosteroid OR
    D. Patient has a diagnosis of hypereosinophilic syndrome (HES) for 6 months or more without an identifiable non-hematologic secondary cause AND the following:
        i. ONE of the following:
            a. Patient is currently being treated with maintenance therapy with oral corticosteroid OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to oral corticosteroid OR
    E. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND
3. Patient has had clinical benefit with the requested agent AND
4. Patient will NOT be using the requested agent in combination with Xolair, Dupixent, or with another injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Exdensur, Fasenra) for the requested indication

Part B Prerequisite:

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:
Nuedexta PA
Drug Name(s)
Nuedexta
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of pseudobulbar affect OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Nuplazid PA
Drug Name(s)
Nuplazid
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Nurtec PA
Drug Name(s)
Nurtec
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Omnipod PA
Drug Name(s)
Omnipod Go
Omnipod Kit
Omnipod Pods
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of diabetes mellitus AND
2. Patient is on an insulin regimen of 3 or more injections per day AND
3. ONE of the following:
    A. Patient is testing glucose levels 4 or more times per day OR
    B. Patient is using a continuous glucose monitor (CGM)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of diabetes mellitus AND
3. Patient has had clinical benefit with the requested agent (e.g., stable or improved glycemic control)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Ophthalmic Immunomodulators PA - Xiidra
Drug Name(s)
Xiidra
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Opioids ER PA - Buprenorphine Pain
Drug Name(s)
Buprenorphine
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of cancer-related pain OR
    B. Patient has a diagnosis of pain due to sickle cell disease OR
    C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. ALL of the following:
            a. Prescriber has completed a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis AND
            b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
            c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
            d. ONE of the following:
                1. Patient's medication history includes use of an immediate-acting opioid OR
                2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR
                3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND
            e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND
            f. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:
Opioids ER PA - Fentanyl Patch
Drug Name(s)
Fentanyl
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of cancer-related pain OR
    B. Patient has a diagnosis of pain due to sickle cell disease OR
    C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. ALL of the following:
            a. Prescriber has completed a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis AND
            b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
            c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
            d. ONE of the following:
                1. Patient's medication history includes use of an immediate-acting opioid OR
                2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR
                3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND
            e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND
            f. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No

Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Opioids ER PA - Morphine
Drug Name(s)
Morphine Sulfate Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of cancer-related pain OR
    B. Patient has a diagnosis of pain due to sickle cell disease OR
    C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. ALL of the following:
            a. Prescriber has completed a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis AND
            b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
            c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
            d. ONE of the following:
                1. Patient's medication history includes use of an immediate-acting opioid OR
                2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR
                3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND
            e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND
            f. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No

Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Opioids ER PA - Tramadol
Drug Name(s)
Tramadol Hcl Er
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of cancer-related pain OR
    B. Patient has a diagnosis of pain due to sickle cell disease OR
    C. Patient is undergoing treatment of chronic non-cancer pain AND ONE of the following:
        i. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 90 days OR
        ii. Prescriber states the patient is currently being treated with the requested agent within the past 90 days OR
        iii. ALL of the following:
            a. Prescriber has completed a formal, consultative evaluation including BOTH of the following:
                1. Diagnosis AND
                2. A medical history which includes previous and current pharmacological and non-pharmacological therapy for the requested diagnosis AND
            b. The requested agent is NOT prescribed as an as-needed (prn) analgesic AND
            c. Prescriber has confirmed that a patient-specific pain management plan is on file for the patient AND
            d. ONE of the following:
                1. Patient's medication history includes use of an immediate-acting opioid OR
                2. Patient has an intolerance or hypersensitivity to an immediate-acting opioid OR
                3. Patient has an FDA labeled contraindication to an immediate-acting opioid AND
            e. Prescriber has reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose AND
            f. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No

Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Otezla PA
Drug Name(s)
Otezla
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Otezla XR PA
Drug Name(s)
Otezla Xr
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Ozempic Inj PA
Drug Name(s)
Ozempic Inj
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR
    C. ALL of the following:
        i. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND
        iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Ozempic Tablet PA
Drug Name(s)
Ozempic Tab
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR
    C. ALL of the following:
        i. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND
        iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Panretin PA
Drug Name(s)
Panretin
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. ONE of the following:
            1. BOTH of the following:
                a. Patient has a diagnosis of cutaneous lesions associated with AIDS-related Kaposi's sarcoma (KS) AND
                b. Patient does NOT require systemic anti-Kaposi's sarcoma therapy OR
            2. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Prescriber is a specialist in the area of the patient's diagnosis (e.g., oncologist, dermatologist, infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND
        iii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Pegasys PA
Drug Name(s)
Pegasys
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of chronic hepatitis B AND BOTH of the following:
        i. The chronic hepatitis B infection has been confirmed by serological markers AND
        ii. Patient has NOT been administered the requested agent for more than 48 weeks for the treatment of chronic hepatitis B OR
    B. BOTH of the following:
        i. Patient has a diagnosis of chronic hepatitis C confirmed by serological markers AND
        ii. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling for the patient's diagnosis and genotype OR
    C. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
12 months for all other diagnoses. For hep B, hep C see Other Criteria
Other Criteria:
No prior peginterferon alfa use, approve 48 weeks for hepatitis B infection. Prior peginterferon alfa use, approve remainder of 48 weeks of total therapy for hepatitis B infection

Duration of therapy for hepatitis C: Based on FDA approved labeling
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Pirfenidone PA
Drug Name(s)
Pirfenidone
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Posaconazole PA
Drug Name(s)
Posaconazole Dr
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Pulmonary Hypertension PA - Adempas
Drug Name(s)
Adempas
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Pulmonary Hypertension PA - Ambrisentan
Drug Name(s)
Ambrisentan
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Pulmonary Hypertension PA - Orenitram
Drug Name(s)
Orenitram
Orenitram Titration Kit
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Pulmonary Hypertension PA - Sildenafil
Drug Name(s)
Sildenafil Citrate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Concurrently taking another phosphodiesterase 5 (PDE5) inhibitor with the requested agent AND FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Pulmonary Hypertension PA - Tadalafil
Drug Name(s)
Tadalafil Tablet 20Mg
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Concurrently taking another phosphodiesterase 5 (PDE5) inhibitor with the requested agent AND FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Pulmonary Hypertension PA - Winrevair
Drug Name(s)
Winrevair
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Pyrimethamine PA
Drug Name(s)
Pyrimethamine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 6 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Pyrukynd PA
Drug Name(s)
Pyrukynd
Pyrukynd Taper Pack
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require the following:
1. Patient has a diagnosis of hemolytic anemia with pyruvate kinase deficiency (PKD) AND ALL of the following:
    A. ONE of the following:
        i. Genetic testing showing a pathogenic PKLR gene mutation OR
        ii. Patient does NOT have two known pathogenic mutations in the PKLR gene, AND patient has a decrease in pyruvate kinase enzyme activity AND
    B. Patient is NOT homozygous for the c.1436G to A (p.R479H) variant AND
    C. Patient has at least 2 variant alleles in the PKLR gene, of which at least 1 is a missense variant AND
    D. Patient does NOT have two non-missense mutations

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of hemolytic anemia with pyruvate kinase deficiency (PKD) AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., hematologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Quinine PA
Drug Name(s)
Quinine Sulfate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has ONE of the following diagnoses:
    A. Uncomplicated malaria OR
    B. An indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be 7 days for malaria,12 months for all other diagnoses
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Repatha PA
Drug Name(s)
Repatha
Repatha Sureclick
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Revcovi PA
Drug Name(s)
Revcovi
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of adenosine deaminase severe combined immune deficiency (ADA-SCID) confirmed by ONE of the following:
    A. Molecular genetic confirmation of mutations in both alleles of the ADA1 gene OR
    B. Deficiency or absence of ADA in lysed erythrocytes, fibroblasts (cultured from amniotic fluid), or chorionic villus OR
    C. Positive screening by T cell receptor excision circles (TRECs) OR
    D. Increase in deoxyadenosine triphosphate (dATP) levels in erythrocyte lysates over the testing laboratory's upper limit of the normal range AND
2. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of adenosine deaminase severe combined immune deficiency (ADA-SCID) AND
3. Patient has had clinical benefit with the requested agent AND
4. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., hematologist, immunologist, oncologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Rezdiffra PA
Drug Name(s)
Rezdiffra
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Decompensated cirrhosis AND Moderate to severe hepatic impairment (Child-Pugh Class B or C)
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Rezurock PA
Drug Name(s)
Rezurock
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. Patient has a diagnosis of chronic graft-versus-host disease (chronic GVHD) AND
2. Patient has failed at least two prior lines of systemic therapy

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of chronic graft-versus-host disease (chronic GVHD) AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., hematologist, oncologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Ritalin PA
Drug Name(s)
Methylphenidate Hcl (Ritalin)
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Roflumilast PA
Drug Name(s)
Roflumilast
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. Patient is currently being treated with a long-acting beta-2 agonist (LABA) and long-acting muscarinic antagonist (LAMA) combination with or without an inhaled corticosteroid (ICS) OR
    B. Patient has an intolerance or hypersensitivity to a long-acting beta-2 agonist (LABA) and long-acting muscarinic antagonist (LAMA) combination OR
    C. Patient has an FDA labeled contraindication to a long-acting beta-2 agonist (LABA) and long-acting muscarinic antagonist (LAMA) combination
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Rufinamide PA
Drug Name(s)
Rufinamide
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Rybelsus PA
Drug Name(s)
Rybelsus
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR
    C. ALL of the following:
        i. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND
        iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Sapropterin PA
Drug Name(s)
Sapropterin Dihydrochloride
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of phenylketonuria (PKU) AND
2. Prescriber has submitted a baseline blood Phe level measured prior to initiation of therapy with the requested agent, which is above the recommended levels indicated for the patient's age range or condition AND
3. Patient will NOT be using the requested agent in combination with Palynziq (pegvaliase-pqpz) or Sephience (sepiapterin) for the requested indication AND
4. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of phenylketonuria (PKU) AND
3. ONE of the following:
    A. Patient's blood Phe levels are being maintained within the acceptable range OR
    B. Patient has had a decrease in blood Phe level from baseline AND
4. Patient will NOT be using the requested agent in combination with Palynziq (pegvaliase-pqpz) or Sephience (sepiapterin) for the requested indication AND
5. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., metabolic or genetic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Afinitor
Drug Name(s)
Everolimus Tab
Torpenz
Yulithira
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Afinitor Disperz
Drug Name(s)
Everolimus Tab (for Oral Susp)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Akeega
Drug Name(s)
Akeega
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Alecensa
Drug Name(s)
Alecensa
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Alunbrig
Drug Name(s)
Alunbrig
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Augtyro
Drug Name(s)
Augtyro
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Avmapki Fakzynja
Drug Name(s)
Avmapki Fakzynja Co-Pack
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Ayvakit
Drug Name(s)
Ayvakit
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Balversa
Drug Name(s)
Balversa
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Besremi
Drug Name(s)
Besremi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Bosulif Capsule
Drug Name(s)
Bosulif Cap
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Bosulif Tablet
Drug Name(s)
Bosulif Tab
Bosutinib Tab
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Braftovi
Drug Name(s)
Braftovi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Brukinsa
Drug Name(s)
Brukinsa
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Cabometyx
Drug Name(s)
Cabometyx
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Calquence
Drug Name(s)
Calquence
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Caprelsa
Drug Name(s)
Caprelsa
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Cavhanza
Drug Name(s)
Cavhanza
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Cometriq
Drug Name(s)
Cometriq
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Copiktra
Drug Name(s)
Copiktra
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Cotellic
Drug Name(s)
Cotellic
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Danziten
Drug Name(s)
Danziten
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Daurismo
Drug Name(s)
Daurismo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Ensacove
Drug Name(s)
Ensacove
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Erivedge
Drug Name(s)
Erivedge
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Erleada
Drug Name(s)
Erleada
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Fotivda
Drug Name(s)
Fotivda
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Fruzaqla
Drug Name(s)
Fruzaqla
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Gavreto
Drug Name(s)
Gavreto
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Gilotrif
Drug Name(s)
Gilotrif
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Gleevec
Drug Name(s)
Imatinib Mesylate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Gomekli
Drug Name(s)
Gomekli
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Hernexeos
Drug Name(s)
Hernexeos
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Hyrnuo
Drug Name(s)
Hyrnuo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Ibrance
Drug Name(s)
Ibrance
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Ibtrozi
Drug Name(s)
Ibtrozi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Iclusig
Drug Name(s)
Iclusig
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Idhifa
Drug Name(s)
Idhifa
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Imbruvica
Drug Name(s)
Imbruvica
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Imkeldi
Drug Name(s)
Imkeldi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Inluriyo
Drug Name(s)
Inluriyo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Inlyta
Drug Name(s)
Inlyta
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Inqovi
Drug Name(s)
Inqovi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Inrebic
Drug Name(s)
Inrebic
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Iressa
Drug Name(s)
Gefitinib
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Itovebi
Drug Name(s)
Itovebi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Iwilfin
Drug Name(s)
Iwilfin
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Jakafi
Drug Name(s)
Jakafi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Jaypirca
Drug Name(s)
Jaypirca
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Kisqali
Drug Name(s)
Kisqali
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Komzifti
Drug Name(s)
Komzifti
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
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    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Koselugo
Drug Name(s)
Koselugo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
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        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Krazati
Drug Name(s)
Krazati
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Lazcluze
Drug Name(s)
Lazcluze
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Lenvima
Drug Name(s)
Lenvima
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Lifyorli
Drug Name(s)
Lifyorli
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Lonsurf
Drug Name(s)
Lonsurf
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Lorbrena
Drug Name(s)
Lorbrena
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Lumakras
Drug Name(s)
Lumakras
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Lynparza
Drug Name(s)
Lynparza
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Lytgobi
Drug Name(s)
Lytgobi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Matulane
Drug Name(s)
Matulane
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Mekinist
Drug Name(s)
Mekinist
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
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        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Mektovi
Drug Name(s)
Mektovi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Modeyso
Drug Name(s)
Modeyso
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Nerlynx
Drug Name(s)
Nerlynx
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Nexavar
Drug Name(s)
Sorafenib
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Ninlaro
Drug Name(s)
Ninlaro
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Nubeqa
Drug Name(s)
Nubeqa
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Odomzo
Drug Name(s)
Odomzo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Ogsiveo
Drug Name(s)
Ogsiveo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Ojemda
Drug Name(s)
Ojemda
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Ojjaara
Drug Name(s)
Ojjaara
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Onureg
Drug Name(s)
Onureg
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Orgovyx
Drug Name(s)
Orgovyx
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Orserdu
Drug Name(s)
Orserdu
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Pemazyre
Drug Name(s)
Pemazyre
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Piqray
Drug Name(s)
Piqray
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Pomalyst
Drug Name(s)
Pomalidomide
Pomalyst
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Qinlock
Drug Name(s)
Qinlock
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Retevmo
Drug Name(s)
Retevmo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Revlimid
Drug Name(s)
Lenalidomide
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Revuforj
Drug Name(s)
Revuforj
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Rezlidhia
Drug Name(s)
Rezlidhia
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Romvimza
Drug Name(s)
Romvimza
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Rozlytrek
Drug Name(s)
Rozlytrek
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Rubraca
Drug Name(s)
Rubraca
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Rydapt
Drug Name(s)
Rydapt
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Scemblix
Drug Name(s)
Scemblix
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Sprycel
Drug Name(s)
Dasatinib
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Stivarga
Drug Name(s)
Stivarga
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Sutent
Drug Name(s)
Sunitinib Malate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Tabrecta
Drug Name(s)
Tabrecta
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Tafinlar
Drug Name(s)
Tafinlar
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
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        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Tagrisso
Drug Name(s)
Tagrisso
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Talzenna
Drug Name(s)
Talzenna
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Tarceva
Drug Name(s)
Erlotinib Hcl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
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        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Targretin Capsule
Drug Name(s)
Bexarotene Cap
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Tasigna
Drug Name(s)
Nilotinib
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Tepmetko
Drug Name(s)
Tepmetko
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
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        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Thalomid
Drug Name(s)
Thalomid
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Tibsovo
Drug Name(s)
Tibsovo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
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        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Tretinoin Capsule
Drug Name(s)
Tretinoin Cap
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Truqap
Drug Name(s)
Truqap
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Tukysa
Drug Name(s)
Tukysa
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Turalio
Drug Name(s)
Turalio
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
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        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Tykerb
Drug Name(s)
Lapatinib Ditosylate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Vanflyta
Drug Name(s)
Vanflyta
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Venclexta
Drug Name(s)
Venclexta
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Veppanu
Drug Name(s)
Veppanu
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
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    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Verzenio
Drug Name(s)
Verzenio
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
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    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Vitrakvi
Drug Name(s)
Vitrakvi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Vizimpro
Drug Name(s)
Vizimpro
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Vonjo
Drug Name(s)
Vonjo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Voranigo
Drug Name(s)
Voranigo
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Votrient
Drug Name(s)
Pazopanib Hcl
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Welireg
Drug Name(s)
Welireg
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Xalkori
Drug Name(s)
Xalkori
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Xospata
Drug Name(s)
Xospata
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Xpovio
Drug Name(s)
Xpovio
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Xtandi
Drug Name(s)
Xtandi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Yonsa
Drug Name(s)
Yonsa
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Zejula
Drug Name(s)
Zejula
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Zelboraf
Drug Name(s)
Zelboraf
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Zolinza
Drug Name(s)
Zolinza
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Self Administered Oncology PA - Zydelig
Drug Name(s)
Zydelig
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Zykadia
Drug Name(s)
Zykadia
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. ALL of the following:
        i. Genetic testing has been completed, if required, for therapy with the requested agent and results indicate the requested agent is appropriate AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        iii. Patient does NOT have any FDA labeled limitations of use that are not otherwise supported in NCCN guidelines
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Self Administered Oncology PA - Zytiga
Drug Name(s)
Abiraterone Acetate
Abirtega
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Signifor PA
Drug Name(s)
Signifor
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Severe hepatic impairment (i.e., Child Pugh C)
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of Cushing's disease (CD) AND ONE of the following:
        i. Patient had an inadequate response to pituitary surgical resection OR
        ii. Patient is NOT a candidate for pituitary surgical resection OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require BOTH of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of Cushing's disease (CD) AND BOTH of the following:
        i. Patient has a urinary free cortisol level less than or equal to the upper limit of normal AND
        ii. Patient has had improvement in at least ONE of the following clinical signs and symptoms:
            1. Fasting plasma glucose OR
            2. Hemoglobin A1c OR
            3. Hypertension OR
            4. Weight OR
    B. BOTH of the following:
        i. Patient has an indication that is supported in CMS approved compendia for the requested agent AND
        ii. Patient has had clinical benefit with the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Sirturo PA
Drug Name(s)
Sirturo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of pulmonary tuberculosis (TB) due to Mycobacterium tuberculosis resistant to at least rifampin and isoniazid AND
2. The requested agent will be used in combination with other anti-infectives AND
3. The requested dose is within FDA labeled dosing for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., infectious disease, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Sivextro PA
Drug Name(s)
Sivextro
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has ONE of the following:
    A. BOTH of the following:
        i. A documented acute bacterial skin and skin structure infection (ABSSSI) defined as a bacterial infection of the skin with a lesion size area of at least 75 cm2 (lesion size measured by the area of redness, edema, or induration) AND
        ii. The infection is due to Staphylococcus aureus, Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus anginosus, Streptococcus intermedius, Streptococcus constellatus, or Enterococcus faecalis OR
    B. Another indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. The requested agent is prescribed by an infectious disease specialist or the prescriber has consulted with an infectious disease specialist on treatment of this patient OR
    B. The requested agent is NOT prescribed by an infectious disease specialist or the prescriber has NOT consulted with an infectious disease specialist on treatment of this patient AND ONE of the following:
        i. There is documentation of resistance to TWO of the following: beta-lactams, macrolides, clindamycin, tetracycline, or co-trimoxazole at the site of infection OR
        ii. Patient has an intolerance or hypersensitivity to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR
        iii. Patient has an FDA labeled contraindication to TWO of the following: beta-lactams, macrolides, clindamycin, tetracyclines, or co-trimoxazole OR
        iv. There is documentation of resistance to vancomycin at the site of infection OR
        v. Patient has an intolerance or hypersensitivity to vancomycin OR
        vi. Patient has an FDA labeled contraindication to vancomycin AND
3. Patient will NOT be using the requested agent in combination with linezolid for the same infection AND
4. The requested dose is within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be 6 days for ABSSSI or 30 days for all other indications
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:
Sodium Oxybate PA
Drug Name(s)
Sodium Oxybate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. Patient has a diagnosis of narcolepsy with cataplexy as confirmed by a sleep study OR
    B. BOTH of the following:
        i. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness as confirmed by a sleep study AND
        ii. ONE of the following:
            a. Patient is between the ages of 7 and less than 18 years OR
            b. BOTH of the following:
                1. Patient is 18 years of age or over AND
                2. ONE of the following:
                    a) Patient has tried and had an inadequate response to modafinil or armodafinil OR
                    b) Patient has an intolerance or hypersensitivity to modafinil or armodafinil OR
                    c) Patient has an FDA labeled contraindication to modafinil or armodafinil OR
    C. Patient has another indication that is supported in CMS approved compendia for the requested agent

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. Patient has a diagnosis of narcolepsy with cataplexy OR
    B. Patient has a diagnosis of narcolepsy with excessive daytime sleepiness OR
    C. Patient has another indication that is supported in CMS approved compendia for the requested agent AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
For diagnosis of narcolepsy with cataplexy, patient is 7 years of age or over. For diagnosis of narcolepsy with excessive daytime sleepiness, patient is 7 years of age or over.
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist, psychiatrist, sleep specialist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Somatostatin Analogs PA - Octreotide
Drug Name(s)
Octreotide Acetate
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Somatostatin Analogs PA - Somavert
Drug Name(s)
Somavert
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Tarpeyo PA
Drug Name(s)
Tarpeyo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Tasimelteon Capsule PA
Drug Name(s)
Tasimelteon
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require the following:
1. ONE of the following:
    A. BOTH of the following:
        i. Patient has a diagnosis of Non-24-hour sleep-wake disorder AND
        ii. Patient is totally blind (i.e., no light perception) OR
    B. BOTH of the following:
        i. Patient has a diagnosis of Smith-Magenis Syndrome (SMS) confirmed by the presence of ONE of the following genetic mutations:
            a. A heterozygous deletion of 17p11.2 OR
            b. A heterozygous pathogenic variant involving RAI1 AND
        ii. The requested agent is being used to treat nighttime sleep disturbances associated with SMS

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:
    A. BOTH of the following:
        i. Patient has a diagnosis of Non-24-hour sleep-wake disorder AND
        ii. Patient is totally blind (i.e., no light perception) OR
    B. BOTH of the following:
        i. Patient has a diagnosis of Smith-Magenis Syndrome (SMS) AND
        ii. The requested agent is being used to treat nighttime sleep disturbances associated with SMS AND
3. Patient has had clinical benefit with the requested agent
Age Restriction:
For diagnosis of Non-24-hour sleep-wake disorder, patient is 18 years of age or over. For diagnosis of Smith-Magenis Syndrome (SMS), patient is 16 years of age or over.
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist, sleep specialist, psychiatrist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Teriparatide PA
Drug Name(s)
Bonsity
Teriparatide
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Testosterone Topical Gel PA
Drug Name(s)
Testosterone Gel
Testosterone Pump
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Tetrabenazine PA
Drug Name(s)
Tetrabenazine
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Tobi Podhaler PA
Drug Name(s)
Tobi Podhaler
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. Documentation has been provided that indicates the patient has a Pseudomonas aeruginosa respiratory infection AND
3. ONE of the following:
    a. Patient is NOT currently (within the past 56 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam) OR
    b. Patient is currently (within the past 56 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam) AND ONE of the following:
        i. Prescriber has confirmed that the other inhaled antibiotic will be discontinued, and that therapy will be continued only with the requested agent OR
        ii. Prescriber has provided information in support of another inhaled antibiotic therapy used concurrently with or alternating with (i.e., continuous alternating therapy) the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Tobramycin neb PA
Drug Name(s)
Tobramycin Neb
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of cystic fibrosis AND
2. Documentation has been provided that indicates the patient has a Pseudomonas aeruginosa respiratory infection AND
3. ONE of the following:
    a. Patient is NOT currently (within the past 56 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam) OR
    b. Patient is currently (within the past 56 days) being treated with another inhaled antibiotic (e.g., inhaled aztreonam) AND ONE of the following:
        i. Prescriber has confirmed that the other inhaled antibiotic will be discontinued, and that therapy will be continued only with the requested agent OR
        ii. Prescriber has provided information in support of another inhaled antibiotic therapy used concurrently with or alternating with (i.e., continuous alternating therapy) the requested agent

Drug is also subject to Part B versus Part D review.
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Topical Diclofenac 3% Gel PA
Drug Name(s)
Diclofenac Sodium Gel 3%
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has a diagnosis of actinic keratosis (AK)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 3 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Topical NSAID PA - Pennsaid
Drug Name(s)
Diclofenac Sodium (Pennsaid)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    a. Patient has an FDA labeled indication for the requested agent OR
    b. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be 3 months for acute pain, 12 months for all other diagnoses
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Topical Retinoids PA - Tazarotene
Drug Name(s)
Tazarotene
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for cosmetic purposes
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Topical Retinoids PA - Tretinoin
Drug Name(s)
Tretinoin (Topical)
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for cosmetic purposes
Required Medical Information:
Criteria for approval require the following:
1. ONE of the following:
    A. Patient has an FDA labeled indication for the requested agent OR
    B. Patient has an indication that is supported in CMS approved compendia for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Trelstar PA
Drug Name(s)
Trelstar Mixject
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication or an indication that is supported in CMS approved compendia for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent OR
    C. BOTH of the following:
        i. Patient is NOT currently being treated with the requested agent AND
        ii. Patient does NOT have any FDA labeled contraindications to the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Trientine PA
Drug Name(s)
Trientine Hcl
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Trikafta PA
Drug Name(s)
Trikafta
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Trulicity PA
Drug Name(s)
Trulicity
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone
Required Medical Information:
Criteria for approval require BOTH of the following:
1. Patient has an FDA labeled indication for the requested agent AND
2. ONE of the following:
    A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 180 days OR
    B. Prescriber states the patient is currently being treated with the requested agent within the past 180 days OR
    C. ALL of the following:
        i. Patient does NOT have any FDA labeled contraindications to the requested agent AND
        ii. Patient will NOT be using the requested agent in combination with another GLP-1 agonist agent, or an agent containing a GLP-1 agonist AND
        iii. Patient will NOT be using the requested agent in combination with an agent containing a dipeptidyl peptidase-4 (DPP-4) inhibitor
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Tymlos PA
Drug Name(s)
Tymlos
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Urea Cycle Disorders PA - Buphenyl
Drug Name(s)
Sodium Phenylbutyrate
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has a diagnosis of ONE of the following:
    A. Urea cycle disorder with neonatal-onset involving deficiencies of carbamylphosphate synthetase, ornithine transcarbamylase, or argininosuccinic acid synthetase OR
    B. Urea cycle disorder with late-onset and history of hyperammonemic encephalopathy involving deficiencies of carbamylphosphate synthetase, ornithine transcarbamylase, or argininosuccinic acid synthetase
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist, metabolic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Valchlor PA
Drug Name(s)
Valchlor
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Veozah PA
Drug Name(s)
Veozah
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has an FDA labeled indication for the requested agent
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Voriconazole PA
Drug Name(s)
Voriconazole
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Vosevi PA
Drug Name(s)
Vosevi
Indications:
All Medically-Accepted Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of hepatitis C confirmed by serological markers AND
2. Prescriber has screened the patient for current or prior hepatitis B viral (HBV) infection and if positive, will monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent AND
3. The requested agent will be used in a treatment regimen and length of therapy that is supported in FDA approved labeling or AASLD/IDSA guidelines for the patient's diagnosis and genotype AND
4. The requested dose is within FDA labeled dosing or supported in AASLD/IDSA guideline dosing for the requested indication AND
5. If genotype 1, the patient's subtype has been identified and provided
Age Restriction:
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist or infectious disease) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Duration of therapy: Based on FDA approved labeling or AASLD/IDSA guideline supported
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Vowst PA
Drug Name(s)
Vowst
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Wegovy Inj PA
Drug Name(s)
Wegovy Inj
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone AND FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Wegovy Tablet PA
Drug Name(s)
Wegovy Tab
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Requested agent will be used for weight loss alone AND FDA labeled contraindications to the requested agent
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Xdemvy PA
Drug Name(s)
Xdemvy
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review

Prior Authorization Group Description:
Xermelo PA
Drug Name(s)
Xermelo
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. Patient has a diagnosis of carcinoid syndrome diarrhea AND
2. Patient has tried and had an inadequate response to treatment with a somatostatin analog (e.g., octreotide) AND
3. The requested agent will be used in combination with a somatostatin analog (e.g., octreotide)

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of carcinoid syndrome diarrhea AND
3. Patient has had clinical benefit with the requested agent (e.g., reduction in the average number of daily bowel movements) AND
4. The requested agent will be used in combination with a somatostatin analog (e.g., octreotide)
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
Yes

Prior Authorization Group Description:
Xifaxan 200 MG Tablet PA
Drug Name(s)
Xifaxan 200Mg
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require ALL of the following:
1. Patient has a diagnosis of traveler's diarrhea (TD) AND
2. Patient's traveler's diarrhea is caused by noninvasive strains of Escherichia coli AND
3. Patient's diarrhea is not complicated by fever or blood in the stool
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Xifaxan 550 MG Tablet PA
Drug Name(s)
Xifaxan 550Mg
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for approval require the following:
1. Patient has ONE of the following:
    a. A diagnosis of irritable bowel syndrome with diarrhea (IBS-D) OR
    b. A diagnosis of hepatic encephalopathy [reduction in risk of overt hepatic encephalopathy (HE) recurrence]
Age Restriction:
Prescriber Restrictions:
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Xolair PA
Drug Name(s)
Xolair
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Criteria for initial approval require ALL of the following:
1. ONE of the following:
    A. Patient has a diagnosis of moderate to severe persistent asthma AND ALL of the following:
        i. ONE of the following:
            a. Patient is 6 to less than 12 years of age AND BOTH of the following:
                1. Patient's pretreatment IgE level is 30 IU/mL to 1300 IU/mL AND
                2. Patient's weight is 20 kg to 150 kg OR
            b. Patient is 12 years of age or over AND BOTH of the following:
                1. Patient's pretreatment IgE level is 30 IU/mL to 700 IU/mL AND
                2. Patient's weight is 30 kg to 150 kg AND
        ii. Allergic asthma has been confirmed by a positive skin test or in vitro reactivity test to a perennial aeroallergen AND
        iii. ONE of the following:
            a. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an asthma control therapy OR
    B. Patient has a diagnosis of chronic spontaneous urticaria (CSU) AND BOTH of the following:
        i. Patient has had over 6 weeks of hives and itching AND
        ii. ONE of the following:
            a. Patient has tried and had an inadequate response to maximum tolerable H1 antihistamine therapy OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to H1 antihistamine therapy OR
    C. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND BOTH of the following:
        i. ONE of the following:
            a. Patient has tried and had an inadequate response to an intranasal corticosteroid OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an intranasal corticosteroid AND
        ii. ONE of the following:
            a. The requested agent will be used in combination with an intranasal corticosteroid OR
            b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an intranasal corticosteroid OR

Initial criteria continues: see Other Criteria

Age Restriction:
For diagnosis of moderate to severe persistent asthma, patient is 6 years of age or over. For diagnosis of chronic spontaneous urticaria (CSU), patient is 12 years of age or over. For diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP), patient is 18 years of age or over. For diagnosis of IgE-mediated food allergy, patient is 1 year of age or over.
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, hematologist, immunologist, oncologist, otolaryngologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:

D. Patient has a diagnosis of IgE-mediated food allergy AND ALL of the following:
i. Patient is using the requested agent for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods AND
ii. IgE-mediated food allergy has been confirmed by an allergy diagnostic test (e.g., skin prick test, serum specific IgE test, oral food challenge) AND
iii. Patient will avoid known food allergens while treated with the requested agent AND
iv. The requested agent will NOT be used for the emergency treatment of allergic reactions, including anaphylaxis AND

2. Patient will NOT be using the requested agent in combination with Dupixent, Rhapsido, or an injectable Interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Exdensur, Fasenra, Nucala) for the requested indication AND
3. The requested dose is within FDA labeled dosing for the requested indication

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. ONE of the following:

A. Patient has a diagnosis of moderate to severe persistent asthma AND BOTH of the following:
i. Patient has had clinical benefit with the requested agent AND
ii. ONE of the following:
a. Patient is currently being treated with AND will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent OR
b. Patient has an intolerance, FDA labeled contraindication, or hypersensitivity to an asthma control therapy OR

B. Patient has a diagnosis of chronic spontaneous urticaria (CSU) AND the following:
a. Patient has had clinical benefit with the requested agent OR

C. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND the following:
a. Patient has had clinical benefit with the requested agent OR

D. Patient has a diagnosis of IgE-mediated food allergy AND ALL of the following:
a. Patient is using the requested agent for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods AND
b. Patient has had clinical benefit with the requested agent AND

c. Patient will avoid known food allergens while treated with the requested agent AND
d. The requested agent will NOT be used for the emergency treatment of allergic reactions, including anaphylaxis AND

3. Patient will NOT be using the requested agent in combination with Dupixent, Rhapsido, or an injectable interleukin 5 (IL-5) inhibitor (e.g., Cinqair, Exdensur, Fasenra, Nucala) for the requested indication AND
4. The requested dose is within FDA labeled dosing for the requested indication

Part B Prerequisite:

No

Prerequisite Therapy Required:

Yes

Prior Authorization Group Description:
Zokinvy PA
Drug Name(s)
Zokinvy
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
FDA labeled contraindications to the requested agent
Required Medical Information:
Criteria for initial approval require BOTH of the following:
1. ONE of the following:
    A. BOTH of the following:
        i. Patient has a diagnosis of Hutchinson-Gilford progeria syndrome (HGPS) AND
        ii. Genetic testing has confirmed a pathogenic variant in the LMNA gene that results in production of progerin OR
    B. Patient has a diagnosis of processing-deficient progeroid laminopathy AND ONE of the following:
        i. Genetic testing has confirmed heterozygous LMNA mutation with progerin-like protein accumulation OR
        ii. Genetic testing has confirmed homozygous or compound heterozygous ZMPSTE24 mutations AND
2. Patient has a body surface area (BSA) of greater than or equal to 0.39 m^2

Criteria for renewal approval require ALL of the following:
1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND
2. Patient has a diagnosis of ONE of the following:
    A. Hutchinson-Gilford progeria syndrome (HGPS) OR
    B. Processing-deficient progeroid laminopathies with either: heterozygous LMNA mutation with progerin-like protein accumulation OR homozygous or compound heterozygous ZMPSTE24 mutations AND
3. Patient has a body surface area (BSA) of greater than or equal to 0.39 m^2 AND
4. Patient has had clinical benefit with the requested agent
Age Restriction:
Patient is within the FDA labeled age for the requested agent
Prescriber Restrictions:
Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis
Coverage Duration:
Approval will be for 12 months
Other Criteria:
Part B Prerequisite:
No
Prerequisite Therapy Required:
No

Prior Authorization Group Description:
Ztalmy PA
Drug Name(s)
Ztalmy
Indications:
All FDA-Approved Indications.
Off-Label Uses:
Exclusion Criteria:
Required Medical Information:
Pending CMS Review