Products Affected

- MAVYRET 100-40MG TAB
- MAVYRET 50-20MG ORAL PELLET

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

Products Affected

- *megestrol acetate 125mg/ml susp*
- *megestrol acetate 40mg/ml susp*

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

Products Affected

- *megestrol acetate 20mg tab (New Starts Only)*
- *megestrol acetate 40mg tab (New Starts Only)*

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

Products Affected

- MEKINIST 0.5MG TAB (New Starts Only)
- MEKINIST 2MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate BRAF V600E or V600K mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– MEKTOVI 15MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate BRAF V600E or V600K mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– *dihydroergotamine mesylate 0.5mg/act nasal inhaler*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trials of 2 different triptans were ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- MOVANTIK 12.5MG TAB
- MOVANTIK 25MG TAB

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

Products Affected

- MYFEMBREE 1-0.5-40MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has failure of, or intolerance to, one hormonal contraceptive.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an obstetrician/gynecologist or women's health/reproductive specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	Member does not have known osteoporosis.

Products Affected

- ABELCET 5MG/ML INJ
- *acetylcysteine 200mg/ml inh soln*
- *albuterol 0.21mg/ml (0.63mg/3ml) inh soln*
- *albuterol 5mg/ml inh soln*
- AMBISOME 50MG INJ
- *aprepitant 125mg cap*
- *aprepitant 40mg cap*
- *arformoterol tartrate 15mcg/2ml neb soln*
- ASTAGRAF 1MG ER CAP
- *azathioprine 100mg tab*
- *azathioprine 75mg tab*
- *budesonide 0.25mg/ml inh susp*
- CLINIMIX 4.25/10 INJ
- CLINIMIX 5/15 INJ
- CLINIMIX E 2.75/5 INJ
- CLINIMIX E 4.25/5 INJ
- CLINIMIX E 5/20 INJ
- CYCLOPHOSPHAMIDE 25MG CAP
- CYCLOPHOSPHAMIDE 50MG CAP
- *cyclosporine 100mg cap*
- *cyclosporine modified 100mg cap*
- *cyclosporine modified 25mg cap*
- DIPHTHERIA/TETANUS TOXOID INJ
- ENGERIX-B 20MCG/ML SYRINGE
- ENVARSUS 1MG ER TAB
- *everolimus 0.25mg tab*
- *everolimus 0.75mg tab*
- FIASP 100UNIT/ML INJ
- *gengraf 100mg cap*
- *acetylcysteine 100mg/ml inh soln*
- *acyclovir 50mg/ml inj*
- *albuterol 0.83mg/ml (0.083%) inh soln*
- *albuterol neb soln 1.25mg/3ml*
- AMPHOTERICIN B 50MG INJ
- *aprepitant 125mg/aprepitant 80mg pack*
- *aprepitant 80mg cap*
- ASTAGRAF 0.5MG ER CAP
- ASTAGRAF 5MG ER CAP
- *azathioprine 50mg tab*
- *budesonide 0.125mg/ml inh susp*
- *budesonide 0.5mg/ml inh susp*
- CLINIMIX 4.25/5 INJ
- CLINIMIX 5/20 INJ
- CLINIMIX E 4.25/10 INJ
- CLINIMIX E 5/15 INJ
- *clinisol 15 inj*
- CYCLOPHOSPHAMIDE 25MG TAB
- CYCLOPHOSPHAMIDE 50MG TAB
- *cyclosporine 25mg cap*
- *cyclosporine modified 100mg/ml oral soln*
- *cyclosporine modified 50mg cap*
- ENGERIX-B 10MCG/0.5ML SYRINGE
- ENVARSUS 0.75MG ER TAB
- ENVARSUS 4MG ER TAB
- *everolimus 0.5mg tab*
- *everolimus 1mg tab*
- *formoterol fumarate neb soln 20mcg/2ml*
- *gengraf 100mg/ml oral soln*

- *gengraf 25mg cap*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 2MG/ML INJ
- *granisetron 1mg tab*
- IMOVAX 2.5UNIT/ML INJ
- *ipratropium bromide 0.2mg/ml inh soln*
- *levalbuterol 0.21mg/ml inh soln*
- *levalbuterol neb soln 1.25mg/0.5ml*
- MEDROL 2MG TAB
- *methylprednisolone 32mg tab*
- *methylprednisolone 8mg tab*
- *mycophenolate mofetil 250mg cap*
- *mycophenolic acid 180mg dr tab*
- NOVOLOG 100UNIT/ML INJ
- *ondansetron 0.8mg/ml oral soln*
- *ondansetron 4mg tab*
- *ondansetron 8mg tab*
- *plenamine 15% inj*
- *prednisolone 15mg odt*
- *prednisolone 30mg odt*
- *prednisone 10mg tab*
- PREDNISONE 1MG/ML ORAL SOLN
- *prednisone 20mg tab*
- *prednisone 5mg tab*
- PREHEVBRIO 10MCG/ML INJ
- PROCALAMINE 3% INJ
- PROGRAF 1MG GRANULES FOR ORAL SUSP
- PULMOZYME 1MG/ML INH SOLN
- RECOMBIVAX 10MCG/ML INJ
- RECOMBIVAX 40MCG/ML INJ
- SANDIMMUNE 100MG/ML ORAL SOLN
- *glucose 100mg/ml inj*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 4.5MG/ML INJ
- HUMULIN R 500UNIT/ML INJ
- INTRALIPID 20GM/100ML INJ
- *ipratropium/albuterol 0.5-2.5mg/3ml inh soln*
- *levalbuterol neb soln 0.31mg/3ml*
- *levalbuterol neb soln 1.25mg/3ml*
- *methylprednisolone 16mg tab*
- *methylprednisolone 4mg tab*
- *mycophenolate mofetil 200mg/ml susp*
- *mycophenolate mofetil 500mg tab*
- *mycophenolic acid 360mg dr tab*
- NUTRILIPID 20GM/100ML INJ
- *ondansetron 4mg odt*
- *ondansetron 8mg odt*
- *pentamidine isethionate 50mg/ml inh soln*
- *prednisolone 10mg odt*
- *prednisolone 1mg/ml oral soln*
- PREDNISOLONE 3MG/ML ORAL SOLN
- *prednisone 1mg tab*
- *prednisone 2.5mg tab*
- *prednisone 50mg tab*
- PREDNISONE 5MG/ML ORAL SOLN
- PREMASOL 10% INJ
- PROGRAF 0.2MG GRANULES FOR ORAL SUSP
- PROSOL 20% INJ
- RABAVERT 2.5UNIT/ML INJ
- RECOMBIVAX 10MCG/ML SYRINGE
- RECOMBIVAX 5MCG/0.5ML SYRINGE
- *sirolimus 0.5mg tab*

- *sirolimus 1mg tab*
- *sirolimus 2mg tab*
- *tacrolimus 1mg cap*
- TDVAX 4-4UNIT/ML INJ
- TRAVASOL 10% INJ
- VARUBI 90MG TAB
- *sirolimus 1mg/ml oral soln*
- *tacrolimus 0.5mg cap*
- *tacrolimus 5mg cap*
- TENIVAC 4-10UNIT/ML SYRINGE
- TROPHAMINE 10% INJ

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

Products Affected

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

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

Products Affected

– NERLYNX 40MG TAB (New Starts Only)

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

Products Affected

– *sorafenib 200mg tab (New Starts Only)*

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

Products Affected

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

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

Products Affected

- *droxidopa 100mg cap*
- *droxidopa 200mg cap*
- *droxidopa 300mg cap*

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

Products Affected

- NOURIANZ 20MG TAB
- NOURIANZ 40MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has tried and failed one agent from both of the following classes when used in combination with carbidopa/levodopa: 1) COMT inhibitor AND 2) MAO-B inhibitor.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease physician or pulmonology specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- NUBEQA 300MG TAB (New Starts Only)

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Asthma diagnosis: Both of the following: A) Peripheral blood eosinophil count is provided and is greater than or equal to 150 cells per microliter. B) History of 1 or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s). For eosinophilic granulomatosis with polyangiitis (EGPA): confirmation of diagnosis required. For hypereosinophilic syndrome: Both of the following: A) Diagnosis confirmed by blood eosinophil count greater than 1000 cells per microliter AND B) Hypereosinophilic syndrome has persisted for at least six months. For nasal polyps: Intolerance to, or failure of therapy of both of the following: a) an oral corticosteroid AND b) a nasal corticosteroid. For continuation requests (all diagnoses): Documentation is provided of positive clinical response.
Age Restrictions	For Severe Asthma diagnosis: Member must be 6 years of age or older. For eosinophilic granulomatosis with polyangiitis (EGPA) diagnosis: Member must be 18 years of age or older. For hypereosinophilic syndrome diagnosis: Member must be 12 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with, an allergy specialist, immunologist, otolaryngologist, pulmonary specialist, gastroenterologist, hematologist, or rheumatologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– NUEDEXTA 20-10MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: A) Documentation is provided of structural neurological condition as the cause of pseudobulbar affect B) Disease severity demonstrated by a score of 13 or greater on the Center for Neurologic Study Lability Scale (CNS-LS) AND C) Member has tried and failed an SSRI. For continuation requests: A) Documentation is provided of structural neurological condition as the cause of pseudobulbar affect B) Member has demonstrated improvement while on Nuedexta, defined as one of the following: i) a score of less than 13 on the Center for Neurologic Study Lability Scale (CNS-LS) OR ii) an improvement of 7 or more points on the CNS-LS. AND C) Member has tried and failed an SSRI.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- NUPLAZID 10MG TAB (New Starts Only)
- NUPLAZID 34MG CAP (New Starts Only)

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

Products Affected

– NURTEC 75MG ODT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For acute treatment of migraine: Trials of 2 different triptans were ineffective or not tolerated. For migraine prevention: Failure of, or intolerance to, both of the following: A) Emgality AND B) Aimovig.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

– NUZYRA 150MG TAB

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

Products Affected

- OCALIVA 10MG TAB
- OCALIVA 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has one of the following: a) inadequate response to a year of therapy with ursodiol OR b) experienced intolerance to ursodiol.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hepatologist or gastroenterologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- *octreotide 0.05mg/ml inj*
- *octreotide 0.1mg/ml inj*
- *octreotide 0.2mg/ml inj*
- *octreotide 0.5mg/ml inj*
- *octreotide 1mg/ml inj*

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

Products Affected

– ODOMZO 200MG CAP (New Starts Only)

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

Products Affected

- OFEV 100MG CAP
- OFEV 150MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) For idiopathic pulmonary fibrosis: Diagnosis confirmed by both of the following: A) No known cause of lung fibrosis AND B) One of the following: i) Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) ii) High-resolution computed tomography (HRCT) indicates definite UIP pattern iii) Both HRCT indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP. 2) For systemic sclerosis-associated iterstitial lung disease (ILD): A) Diagnosis confirmed with documentation provided of both of the following: i) HRCT scan AND ii) pulmonary function tests AND B) Member has tried and failed mycophenolate. 3) For chronic fibrosing ILDs with a progressive phenotype: A) Presence of reticular abnormality with traction bronchiectastis with a disease extent of more than 10% on HRCT AND B) Disease is progressive, defined by one of the following over the past 24 months, despite treatment: i) Forced vital capacity (FVC) decline of 10% or more OR ii) Two of the following: a) FVC decline of 5% or more b) worsening respiratory symptoms c) increasing extent of fibrotic changes on chest imaging AND C) Progression occurred despite treatment with one of the following: i) azathioprine ii) cyclosporine iii) mycophenolate mofetil iv) tacrolimus v) oral corticosteroids equivalent to 20 mg or more per day of prednisone vi) cyclophosphamide vii) rituximab
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist, pulmonologist, or rheumatologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- OLUMIANT 1MG TAB
- OLUMIANT 2MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis: Intolerance to, or failure of therapy with, 2 of the following: a) Humira, b) Enbrel, c) Rinvoq OR d) Xeljanz
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with, a rheumatology specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- ONUREG 200MG TAB (New Starts Only)
- ONUREG 300MG TAB (New Starts Only)

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

Products Affected

- OPSUMIT 10MG TAB

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

Products Affected

- FENTANYL 0.1MG BUCCAL TAB
- FENTANYL 0.2MG BUCCAL TAB
- FENTANYL 0.4MG BUCCAL TAB
- FENTANYL 0.6MG BUCCAL TAB
- FENTANYL 0.8MG BUCCAL TAB
- *fentanyl 1200mcg lozenge*
- *fentanyl 1600mcg lozenge*
- *fentanyl 200mcg lozenge*
- *fentanyl 400mcg lozenge*
- *fentanyl 600mcg lozenge*
- *fentanyl 800mcg lozenge*
- FENTORA 100MCG BUCCAL TAB
- FENTORA 200MCG BUCCAL TAB
- FENTORA 400MCG BUCCAL TAB
- FENTORA 600MCG BUCCAL TAB
- FENTORA 800MCG BUCCAL TAB

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis: Intolerance to, or failure of therapy with, 2 of the following: a) Enbrel, b) Humira, c) Rinvoq OR d) Xeljanz. For polyarticular juvenile idiopathic arthritis: Intolerance to, or failure of therapy with 2 of the following: a) Humira, b) Enbrel OR c) Xeljanz. For Psoriatic Arthritis: Intolerance to, or failure of therapy with, 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Stelara, e) Otezla, f) Skyrizi OR g) Xeljanz.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Rheumatology or Transplant Specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

– ORGOVYX 120MG TAB (New Starts Only)

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

Products Affected

– ORIAHNN 28 DAY KIT PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has failure of, or intolerance to, one hormonal contraceptive.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an obstetrician/gynecologist or women's health/reproductive specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	Member does not have known osteoporosis.

Products Affected

- ORILISSA 150MG TAB
- ORILISSA 200MG TAB

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

Products Affected

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

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

Products Affected

– OSPHENA 60MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance to, or failure of, therapy with both of the following: a) generic estradiol vaginal cream and b) PREMARIN VAGINAL CREAM.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

- *oxandrolone 10mg tab*
- *oxandrolone 2.5mg tab*

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

Products Affected

- OXBRYTA 300MG TAB FOR ORAL SUSP
- OXBRYTA 500MG TAB

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

Products Affected

– OXERVATE 0.002% OPHTH SOLN

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Member is 18 years of age or older.
Prescriber Restriction	Prescribed by or in consultation with, a medical geneticist or metabolic physician.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– PANRETIN 0.1% GEL (New Starts Only)

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

Products Affected

- PRALUENT 150MG/ML AUTO-INJECTOR
- PRALUENT 75MG/ML AUTO-INJECTOR
- REPATHA 140MG/ML AUTO-INJECTOR
- REPATHA 140MG/ML SYRINGE
- REPATHA 420MG/3.5ML CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initiation of therapy patient must: A) Have one of the following conditions: 1) prior clinical atherosclerotic cardiovascular disease (ASCVD) (see Other Criteria), 2) heterozygous familial hypercholesterolemia (HeFH) (see Other Criteria) 3) homozygous familial hypercholesterolemia (HoFH) (see Other Criteria) or 4) Primary hyperlipidemia other than HeFH and HoFH (see Other Criteria) B) Current LDL-C level is over 70 mg/dL. C) one of the following requirements is met: 1) patient has been treated for 8 weeks or more with a high intensity statin (atorvastatin 40mg or greater OR rosuvastatin 20mg or greater), OR 2) patient is intolerant to statins demonstrated by the failure of 2 statins, including an attempt with a low- or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin). Criteria B) and C) not required for HoFH. For continuation of therapy, patient must: A) have one of the following conditions: 1) prior clinical ASCVD (see Other Criteria), 2) HeFH (see Other Criteria), 3) HoFH (see Other Criteria), or 4) Primary hyperlipidemia other than HeFH and HoFH (see Other Criteria) AND B) member had a reduction in LDL-C on PCSK9 inhibitor therapy.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	Clinical ASCVD defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure, prior stroke or transient ischemic attack, or peripheral arterial disease of presumed atherosclerotic origin. Diagnosis of HeFH must be confirmed by one of the following: 1) DNA-based evidence of mutation in the LDLR, Apo B, OR PCSK9 gain of function mutation, 2) Untreated LDL-C greater than 190 mg/dl AND tendon xanthomas in patient or first/second degree relative, 3) Untreated LDL-C greater than 190 mg/dl AND either first degree relative less than 60 years of age or second degree relative less than 50 years of age with premature heart disease, OR 4) untreated LDL-C greater than 190 mg/dl AND first or second degree relative with total cholesterol greater than 290 mg/dL. Diagnosis of HoFH confirmed by all of the following: 1) two parents diagnosed with HeFH or genetic confirmation of LDL

	receptor mutation, AND 2) untreated total cholesterol greater 290 mg/dL or LDL-C greater 190 mg/dL, AND 3) either xanthomas present at 10 years of age or younger or atherosclerotic disease at 20 years of age or younger. Diagnosis of primary hyperlipidemia (other than HeFH and HoFH) includes documentation provided of the diagnosis, which may include, but is not limited to the following conditions: a) Familial hyperchylomicronemia or Buerger-Gruetz Syndrome, b) Familial Combined Hyperlipidemia, c) Familial dysbetalipoproteinemia, d) Familial Triglyceridemia, OR e) Endogenous Hypertriglyceridemia.

Products Affected

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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of PIK3CA-mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

- PREVYMIS 240MG TAB
- PREVYMIS 480MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member will/has initiated Prevymis within 30 days after an allogeneic hematopoietic stem cell transplant.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist, oncologist, transplant or infectious disease specialist.
Coverage Duration	Approved for 4 months.
Other Criteria	

Products Affected

- CRINONE 4% VAGINAL GEL
- CRINONE 8% VAGINAL GEL

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

Products Affected

– PROLIA 60MG/ML SYRINGE

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

Products Affected

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

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

Products Affected

- QBRELIS 1MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is unable to swallow solid dosage forms of lisinopril.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– QINLOCK 50MG TAB (New Starts Only)

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

Products Affected

– *quinine sulfate 324mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month.
Other Criteria	

Products Affected

– RAVICTI 1.1GM/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires trial of sodium phenylbutyrate powder.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a metabolic physician or medical geneticist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– REGRANEX 0.01% GEL

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

Products Affected

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

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

Products Affected

- RETACRIT 10000UNIT/ML INJ
- RETACRIT 20000UNIT/ML INJ
- RETACRIT 3000UNIT/ML INJ
- RETACRIT 4000UNIT/ML INJ
- RETACRIT 20000UNIT/2ML INJ
- RETACRIT 2000UNIT/ML INJ
- RETACRIT 40000UNIT/ML INJ

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

Products Affected

- RETEVMO 40MG CAP (New Starts Only)
- RETEVMO 80MG CAP (New Starts Only)

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

Products Affected

– *sildenafil 20mg tab*

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

Products Affected

- *lenalidomide 10mg cap (New Starts Only)*
- *lenalidomide 15mg cap (New Starts Only)*
- *lenalidomide 25mg cap (New Starts Only)*
- *lenalidomide 5mg cap (New Starts Only)*
- REVLIMID 10MG CAP (New Starts Only)
- REVLIMID 15MG CAP (New Starts Only)
- REVLIMID 2.5MG CAP (New Starts Only)
- REVLIMID 20MG CAP (New Starts Only)
- REVLIMID 25MG CAP (New Starts Only)
- REVLIMID 5MG CAP (New Starts Only)

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

Products Affected

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

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

Products Affected

- REYVOW 100MG TAB
- REYVOW 50MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trials of 2 different triptans were ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– REZUROCK 200MG TAB

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

Products Affected

- RINVOQ 15MG ER TAB
- RINVOQ 30MG ER TAB
- RINVOQ 45MG ER TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Failure of, or intolerance to therapy with one of the following: a) Humira OR b) Enbrel. For Psoriatic Arthritis: Failure of, or one of the following: a) Humira OR b) Enbrel. For Atopic Dermatitis (initial requests): Intolerance to, or failure of therapy of two (2) of the following: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant. For Atopic Dermatitis (continuation requests): Prescriber attests to improvement in the member's condition with use of Rinvoq. For Ulcerative Colitis: Failure of, or intolerance to Humira. For ankylosing spondylitis: Failure of, or intolerance to therapy with one of the following: a) Humira OR b) Enbrel.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis or psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. For ulcerative colitis: Prescribed by, or in consultation with a Gastroenterology Specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living.

Products Affected

- ROZLYTREK 100MG CAP (New Starts Only)
- ROZLYTREK 200MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided showing one of the following: a) ROS1 rearrangement OR b) NTRK gene fusion mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

– RYDAPT 25MG CAP (New Starts Only)

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

Products Affected

- *vigabatrin 500mg powder for oral soln (New Starts Only)*
- *vigabatrin 500mg tab (New Starts Only)*
- *vigadrone 500mg powder for oral soln (New Starts Only)*

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

Products Affected

- SECUADO 3.8MG/24HR PATCH (New Starts Only)
- SECUADO 5.7MG/24HR PATCH (New Starts Only)
- SECUADO 7.6MG/24HR PATCH (New Starts Only)

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

Products Affected

- SCEMBLIX 20MG TAB (New Starts Only)
- SCEMBLIX 40MG TAB (New Starts Only)

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

Products Affected

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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Rheumatoid Arthritis (RA): Intolerance to, or failure of, therapy with 2 of the following: a) Humira, b) Enbrel, c) Rinvoq OR d) Xeljanz. For Ankylosing Spondylitis (AS): Intolerance to, or failure of, therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Rinvoq, OR e) Xeljanz. For Psoriatic Arthritis: Intolerance to, or failure of, therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Stelara, e) Otezla, f) Skyrizi, g) Rinvoq, OR h) Xeljanz. For Ulcerative Colitis: Intolerance to, or failure of, therapy with two of the following: a) Humira, b) Stelara, c) Rinvoq, OR d) Xeljanz.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For ulcerative colitis : Prescribed by, or in consultation with, a gastroenterology specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- SIRTURO 100MG TAB
- SIRTURO 20MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- SIVEXTRO 200MG INJ
- SIVEXTRO 200MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for 6 months.
Other Criteria	

Products Affected

- SKYRIZI 150MG DOSE PACK 75MG/0.83ML
- SKYRIZI 150MG/ML AUTO-INJECTOR
- SKYRIZI 150MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis: Failure of, or intolerance to, therapy with one of the following is required: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) soriatane. For Psoriatic Arthritis: Failure of, or intolerance to one of the following: a) methothrexate OR b) sulfasalazine.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a dermatology specialist. For Psoriatic Arthritis: Prescribed by, or in consultation with, a rheumatology specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– *diclofenac sodium 3% gel*

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

Products Affected

– SOLIQUA PEN INJ

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- SPRITAM 1000MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 250MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 500MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 750MG TAB FOR ORAL SUSP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of, or contraindication to, generic levetiracetam.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Plaque Psoriasis: Failure of, or intolerance to, therapy with one of the following required: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) soriatane. For Psoriatic Arthritis: Failure of, or intolerance to, one of the following required: a) methothrexate OR b) sulfasalazine. For Ulcerative Colitis and Crohn's Disease: Failure of, or intolerance to, one of the following required: a) corticosteroid, b) azathioprine, c) methotrexate OR d) 6-mercaptopurine.
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's Disease and Ulcerative colitis: Prescribed by, or in consultation with, a gastroenterology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatology specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– STIVARGA 40MG TAB (New Starts Only)

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

Products Affected

– SUCRAID 8500UNIT/ML ORAL SOLN

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

Products Affected

- SUNOSI 150MG TAB
- SUNOSI 75MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Failure of, or intolerance to, one of the following: a) modafinil OR b) armodafinil.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep medicine physician.
Coverage Duration	Approved for duration of contract year.
Other Criteria	Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis.

Products Affected

- *sunitinib 12.5mg cap (New Starts Only)*
- *sunitinib 25mg cap (New Starts Only)*
- *sunitinib 37.5mg cap (New Starts Only)*
- *sunitinib 50mg cap (New Starts Only)*

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

Products Affected

- SYMDEKO 50-75MG/75MG PACK
- SYMDEKO TAB 4-WEEK PACK

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

Products Affected

– SYMPROIC 0.2MG TAB

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

Products Affected

– SYNAREL 2MG/ML NASAL INHALER

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

Products Affected

– SYNRIBO 3.5MG INJ (New Starts Only)

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

Products Affected

– *trientine 250mg cap*

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

Products Affected

- TABRECTA 150MG TAB (New Starts Only)
- TABRECTA 200MG TAB (New Starts Only)

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

Products Affected

- TAFINLAR 50MG CAP (New Starts Only)
- TAFINLAR 75MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate BRAF V600E or V600K mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- TAGRISSO 40MG TAB (New Starts Only)
- TAGRISSO 80MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate EGFR mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- TALTZ 80MG/ML AUTO-INJECTOR
- TALTZ 80MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Plaque Psoriasis: Requires failure of, or intolerance to therapy with, one of the following: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) soriatane. For Ankylosing Spondylitis (AS): Requires failure of, or intolerance to sulfasalazine. (Trial of sulfasalazine not required for AS with predominant axial involvement). For Psoriatic Arthritis: Requires failure of, or intolerance to, one of the following: a) methotrexate OR b) sulfasalazine. For Non-radiographic axial spondyloarthritis: Intolerance or failure of therapy with two non-steroidal anti-inflammatory drugs (NSAIDs).
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis, Non-radiographic axial spondyloarthritis and Ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in cosultation with, a dermatology specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- TALZENNA 0.25MG CAP (New Starts Only)
- TALZENNA 0.5MG CAP (New Starts Only)
- TALZENNA 0.75MG CAP (New Starts Only)
- TALZENNA 1MG CAP (New Starts Only)

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate EGFR mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- *bexarotene 1% gel (New Starts Only)*
- *bexarotene 75mg cap (New Starts Only)*

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

Products Affected

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

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

Products Affected

- TAVALISSE 100MG TAB
- TAVALISSE 150MG TAB

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

Products Affected

– TAVNEOS 10MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is positive for antibodies to one of the following: a) proteinase 3 OR b) myeloperoxidase.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatologist or nephrologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- *tazarotene 0.1% cream*
- TAZORAC 0.05% CREAM

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

Products Affected

– TAZVERIK 200MG TAB (New Starts Only)

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

Products Affected

– TEGSEDI 284MG/1.5ML SYRINGE

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

Products Affected

– TEPMETKO 225MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of MET exon 14 skipping mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- ANDRODERM 2MG/24HR PATCH
- *testosterone 1% (12.5mg/act) gel pump*
- *testosterone 1% (50mg) gel packet*
- *testosterone 1.62% (2.5gm) gel packet*
- *testosterone 30mg/act topical soln*
- ANDRODERM 4MG/24HR PATCH
- *testosterone 1% (25mg) gel packet*
- *testosterone 1.62% (1.25gm) gel packet*
- *testosterone 1.62% (20.25mg/act) gel pump*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) For new patients: documentation is provided of morning testosterone levels, from two separate days, that fall below the normal range for a healthy adult male. B) For patients already on testosterone replacement therapy: documentation is provided of at least one morning testosterone level from the last 12 months, showing improvement, is required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- *tetrabenazine 12.5mg tab*
- *tetrabenazine 25mg tab*

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

Products Affected

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

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

Products Affected

– TIBSOVO 250MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of IDH1 mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– *tobramycin 60mg/ml inh soln*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease physician or pulmonology specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

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

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

Products Affected

- TREMFYA 100MG/ML AUTO-INJECTOR
- TREMFYA 100MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis: Intolerance to, or failure of, therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Skyrizi, e) Stelara OR f) Otezla. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: a) Humira, b) Enbrel, c) Taltz, d) Stelara e) Otezla OR f) Xeljanz
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis: Prescribed by, or in consultation, with a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatology specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- TRIKAFTA 100-50-75MG/150MG PACK
- TRIKAFTA 50-37.5-25MG/75MG TAB PACK

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

Products Affected

- TRUSELTIQ 100MG DAILY DOSE CARTON (21) (New Starts Only)
- TRUSELTIQ 125MG DAILY DOSE CARTON (42) (New Starts Only)
- TRUSELTIQ 50MG DAILY DOSE CARTON (42) (New Starts Only)
- TRUSELTIQ 75MG DAILY DOSE CARTON (63) (New Starts Only)

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

Products Affected

- TUKYSA 150MG TAB (New Starts Only)
- TUKYSA 50MG TAB (New Starts Only)

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

Products Affected

– TURALIO 200MG CAP (New Starts Only)

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

Products Affected

– *lapatinib 250mg tab (New Starts Only)*

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

Products Affected

- UBRELVY 100MG TAB
- UBRELVY 50MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trials of 2 different triptans were ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- *budesonide 9mg er tab*
- UCERIS 2MG/ACT RECTAL FOAM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial and failure, or intolerance to mesalamine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

– VALCHLOR 0.016% GEL (New Starts Only)

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

Products Affected

- VELTASSA 16.8GM POWDER FOR ORAL SUSP
- VELTASSA 25.2GM POWDER FOR ORAL SUSP
- VELTASSA 8.4GM POWDER FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) Member has baseline persistent potassium level greater than 5.0 mmol/L. B) Member has tried and failed, or is not a candidate to use Lokelma.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

- VENTAVIS 10MCG/ML INH SOLN
- VENTAVIS 20MCG/ML INH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist or cardiologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- VERQUVO 10MG TAB
- VERQUVO 2.5MG TAB
- VERQUVO 5MG TAB

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

Products Affected

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

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

Products Affected

- VIBERZI 100MG TAB
- VIBERZI 75MG TAB

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

Products Affected

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

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate EGFR mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– VONJO 100MG CAP (New Starts Only)

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an infectious disease physician or oncologist.
Coverage Duration	Approved for 6 months.
Other Criteria	

Products Affected

- VOSEVI 400-100-100MG TAB

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

Products Affected

– VOTRIENT 200MG TAB (New Starts Only)

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

Products Affected

- VOXZOGO 0.4MG INJ
- VOXZOGO 0.56MG INJ
- VOXZOGO 1.2MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: 1) Documentation is provided of the fibroblast growth factor receptor 3 (FGFR3) gene mutation AND 2) Member has open epiphyses. For continuation requests: 1) Epiphyses remain open AND 2) Prescriber attests to improvement in the member's condition with use of the medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a provider specialized in the treatment of achondroplasia.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

- VYNDAMAX 61MG CAP
- VYNDAQEL 20MG CAP

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

Products Affected

- WAKIX 17.8MG TAB
- WAKIX 4.45MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy: failure of, or intolerance to, both of the following: a) Sunosi AND b) either modafinil or armodafinil. For cataplexy, trial of other agents not required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep medicine physician.
Coverage Duration	Approved for duration of contract year.
Other Criteria	For narcolepsy: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

Products Affected

– WELIREG 40MG TAB (New Starts Only)

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

Products Affected

- XALKORI 200MG CAP (New Starts Only)
- XALKORI 250MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of ALK-positive or ROS1-positive disease.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– XATMEP 2.5MG/ML ORAL SOLN

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

Products Affected

- XELJANZ 10MG TAB
- XELJANZ 1MG/ML ORAL SOLN
- XELJANZ 5MG TAB
- XELJANZ 11MG ER TAB
- XELJANZ 22MG ER TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Failure of, or intolerance to therapy with one of the following: a) Humira OR b) Enbrel. For Juvenile Idiopathic Arthritis: Failure of, or intolerance to therapy with one of the following: a) Humira OR b) Enbrel. For Psoriatic Arthritis: Failure of, or one of the following: a) Humira OR b) Enbrel. For ankylosing spondylitis: Failure of, or intolerance to therapy with one of the following: a) Humira OR b) Enbrel. For Ulcerative Colitis: Failure of, or intolerance to Humira.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Juvenile idiopathic arthritis, ankylosing spondylitis, or Psoriatic Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist. For Ulcerative Colitis : Prescribed by, or in consultation with a Gastroenterology Specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– XERMELO 250MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist, endocrinologist, or gastroenterologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	Patient is currently taking somatostatin analog therpy and still experiencing symptoms.

Products Affected

- XGEVA 120MG/1.7ML INJ

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

Products Affected

– XIFAXAN 550MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	For diagnosis of IBS-D, approval will increase quantity limit to 42 tablets over 14 days, maximum of three fills per contract year.

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: For moderate to severe persistent asthma: There must be: A) Objective evidence of reversible airway obstruction B) Member must have a positive skin test or RAST test for specific allergic sensitivity C) One of the following: i) Inadequately controlled asthma despite medium dose of inhaled corticosteroids for at least 3 months in combination with a trial of long-acting inhaled beta-agonists or a leukotriene modifier OR ii) systemic steroids or high dose inhaled corticosteroids are required to maintain adequate asthma control. For chronic idiopathic urticaria: one of the following: a) patient remains symptomatic despite H1 antihistamine treatment OR b) has intolerance or contraindication to H1 antihistamine treatment. For nasal polyps: A) Confirmed diagnosis of nasal polyps (see other criteria) AND B) Trial of Dupixent was ineffective, not tolerated, or contraindicated. For continuation requests (all diagnoses): Documentation is provided of positive clinical response.
Age Restrictions	If for moderate to severe persistent asthma, patient must be at least 6 years old. If for chronic idiopathic urticaria, patient must be at least 12 years old. If for nasal polyps, patient must be at least 18 years old.
Prescriber Restriction	Prescribed by, or in consultation with, an allergist, pulmonologist, dermatologist, ENT specialist, or immunologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	For nasal polyps (initial requests): Diagnosis is confirmed with a sinus CT scan AND at least four of the following apply: a) prior surgery for bilateral nasal polyposis b) evidence of type 2 inflammation c) two or more courses of oral corticosteroids required in the prior year d) significantly impaired quality of life e) significant loss of smell f) diagnosis of comorbid asthma

Products Affected

– XOSPATA 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of FLT3 mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- XPOVIO 100MG ONCE WEEKLY CARTON (8-PACK) (New Starts Onl
- XPOVIO 40MG TWICE WEEKLY CARTON (8-PACK) (New Starts Onl
- XPOVIO 60MG TWICE WEEKLY PACK (New Starts Only)
- XPOVIO 80MG ONCE WEEKLY CARTON (8-PACK) (New Starts Only
- XPOVIO 40MG ONCE WEEKLY CARTON (4-PACK) (New Starts Only
- XPOVIO 60MG ONCE WEEKLY CARTON (4-PACK) (New Starts Only
- XPOVIO 80 MG TWICE WEEKLY (New Starts Only)

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

Products Affected

- XTANDI 40MG CAP (New Starts Only)
- XTANDI 40MG TAB (New Starts Only)
- XTANDI 80MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic castration-resistant prostate cancer (mCRPC) and metastatic castration-sensitive prostate cancer (mCSPC): failure of, intolerance or contraindication to, abiraterone (Zytiga equivalent) required. For nonmetastatic castration-resistant prostate cancer (nmCRPC): failure of, or intolerance to, both of the following: a) Nubeqa and b) Erleada.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or urologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- XULTOPHY 100UNIT-3.6MG/ML PEN INJ

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

Products Affected

– XYREM 500MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy in adults: failure of, or intolerance to, both of the following: a) Sunosi AND b) either modafinil or armodafinil. For cataplexy and patients aged 7 to 17 years: trial of other agents not required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep medicine physician.
Coverage Duration	Approved for duration of contract year.
Other Criteria	For narcolepsy: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

Products Affected

– *miglustat 100mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a medical geneticist, hematologist, or metabolic physician.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– ZEJULA 100MG CAP (New Starts Only)

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

Products Affected

- ZELBORAF 240MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate BRAF V600E or V600 mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- ZEPOSIA 0.92MG CAP
- ZEPOSIA 7-DAY STARTER PACK
- ZEPOSIA STARTER KIT PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Ulcerative Colitis: Intolerance to, or failure of, therapy with two of the following: a) Humira, b) Stelara, c) Rinvoq OR d) Xeljanz.
Age Restrictions	
Prescriber Restriction	For multiple sclerosis: Prescribed by, or in consultation with, a neurology specialist. For ulcerative colitis : Prescribed by, or in consultation with, a gastroenterology specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

– ZOLINZA 100MG CAP (New Starts Only)

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

Products Affected

- ZYDELIG 100MG TAB (New Starts Only)
- ZYDELIG 150MG TAB (New Starts Only)

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

Products Affected

– ZYKADIA 150MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of ALK-positive disease.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	