ALPHA-1 PROTEINASE INHIBITORS

Products Affected

- Aralast NP
- Glassia
- Prolastin-C
- Zemaira

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For initial authorization, all of the following must be met: 1. Documentation of one of the following: a. Serum alpha-1 antitrypsin (AAT) concentrations less than 11 micromol/L (approximately 50 mg/dL by nephelometry or 80 mg/dL by immunodiffusion), or b. Patient has one of the high-risk phenotypes by protease inhibitor (PI) typing: PI*ZZ, PI*Z(null), PI*(null,null), 2. Confirmed diagnosis of emphysema, AND 3. Documentation that dose does not exceed 60 mg/kg every seven (7) days. Criteria 1 and 2 will be waived in patients with concomitant necrotizing panniculitis. Reauthorization requires documentation of response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial authorization will be for 6 months. Reauthorization will be for one year.
Other Criteria	N/A
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

ANTI-CANCER AGENTS

Products Affected

- abiraterone
- Actimmune
- Alecensa
- Alunbrig
- Ayvakit
- Balversa
- Besremi
- bexarotene
- Bosulif
- Braftovi oral capsule 75 mg
- Brukinsa
- Cabometyx
- Calquence
- Calquence (acalabrutinib mal)
- Caprelsa
- Cometriq
- Copiktra
- Cotellic
- Daurismo
- Erivedge
- Erleada
- erlotinib
- everolimus (antineoplastic)
- everolimus (immunosuppressive)
- Exkivity
- Fotivda
- Gavreto
- gefitinib
- Gilotrif
- Gleostine
- Ibrance
- Iclusig
- Idhifa
- imatinib
- Imbruvica oral capsule
- Imbruvica oral suspension
- Imbruvica oral tablet 140 mg, 280 mg, 420 mg
- Inlyta
- Inqovi
- Inrebic
- Iressa
- Jakafi
- Jaypirca
- Kisqali
- Kisqali Femara Co-Pack
- Koselugo
- Krazati
- lapatinib
- lenalidomide
- Lenvima
- Lonsurf
- Lorbrena
- Lumakras
- Lynparza
- Lytgobi
- Mekinist
- Mektovi
- Nerlynx
- nilutamide
- Ninlaro
- Nubeqa
- Odomzo
- Onureg
- Orgovyx
- Orserdu
- Pemazyre
- Piqray
- Pomalyst
- Qinlock

- Retevmo
- Rezlidhia
- Rozlytrek oral capsule
- Rubraca
- Rydapt
- Scemblix
- sorafenib
- Sprycel
- Stivarga
- sunitinib malate
- Synribo
- Tabrecta
- Tafinlar
- Tagrisso
- Talzenna
- Tasigna
- Tazverik
- Tepmetko
- Tibsovo
- toremifene
- tretinoin (antineoplastic)
- Tukysa
- Turalio oral capsule 125 mg
- Venclexta
- Venclexta Starting Pack
- Verzenio
- Vitrakvi
- Vizimpro
- Vonjo
- Votrient
- Welireg
- Xalkori
- Xospata
- Xpovio oral tablet 100 mg/week (50 mg x 2), 40 mg/week (40 mg x 1), 40mg twice week (40 mg x 2), 60 mg/week (60 mg x 1), 60mg twice week (120 mg/week), 80 mg/week (40 mg x 2), 80mg twice week (160 mg/week)
- Xtandi
- Yonsa
- Zejula
- Zelboraf
- Zolinza
- Zydelig
- Zykadia

PA Criteria	Criteria Details
Exclusion Criteria	N/A

PA Criteria	Criteria Details
Required Medical Information	One of the following for initiation of the requested agent: 1. For Bosulif or Tasigna: Documentation of use of imatinib or dasatinib (Sprycel) for the requested indication, unless one of the following: a. The patient has an intolerance or hypersensitivity to imatinib OR dasatinib, b. The patient has an FDA labeled contraindication to imatinib or dasatinib, c. CMS-approved compendia do not support the use of imatinib or dasatinib for the requested indication, or d. The prescriber has provided information in support of use of Bosulif or Tasigna over imatinib or dasatinib for the requested indication. 2. For Calquence: Documentation of use of Brukinsa or Imbruvica for the requested indication (if applicable), unless one of the following: a. The patient has an intolerance or hypersensitivity to Imbruvica or Brukinsa, b. The patient has an FDA labeled contraindication to Imbruvica or Brukinsa, c. CMS-approved compendia do not support the use of Imbruvica or Brukinsa for the requested indication, or d. The prescriber has provided information in support of use of Calquence over Imbruvica or Brukinsa for the requested indication. 3. For everolimus tablets for suspension (generic for Afinitor Disperz): documentation of medical rationale for the use of this formulation over the available everolimus tablet formulation. 4. For all other agents: Indication is supported by CMS-approved compendia.
Age Restrictions	N/A
Prescriber Restrictions	For cancer diagnoses, must be prescribed by or in consultation with an oncologist, transplant specialist, neurologist or, for abiraterone, a urologist. For diagnosis of systemic mast cell disease, allergist or immunologist are also acceptable.

PA Criteria	Criteria Details
Coverage Duration	Authorization will be approved until no longer eligible with the plan.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ANTIDEPRESSANTS

Products Affected

- Fetzima
- Trintellix

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documented trial, failure, intolerance or contraindication to two formulary, generic SSRIs or SNRIs (e.g., citalopram, sertraline, paroxetine, venlafaxine, duloxetine)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial authorization and reauthorization will be approved for one year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ANTIEPILEPTIC AGENTS

Products Affected

- Banzel oral suspension
- Briviact oral
- rufinamide
- Sympazan
- vigabatrin
- Vigadrone
- Xcopri
- Xcopri Maintenance Pack oral tablet 350 mg/day (200 mg x1-150mg x1)
- Xcopri Titration Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of trial and failure of at least one formulary generic antiepileptic medication (divalproex sodium, valproic acid, felbamate, lamotrigine, topiramate, carbamazepine, phenytoin, levetiracetam or clobazam)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be approved until no longer eligible with the plan.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ANTIFUNGAL AGENTS

Products Affected

- Cresemba oral capsule 186 mg
- itraconazole oral solution
- Noxafil oral suspension
- posaconazole oral tablet,delayed release (DR/EC)
- voriconazole

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. For oropharyngeal or esophageal candidiasis (itraconazole solution, posaconazole oral suspension (Noxafil), and voriconazole only): a. For itraconazole solution: Documented failure, intolerance, or contraindication to fluconazole b. For voriconazole or posaconazole oral suspension (Noxafil): Documented failure, intolerance, or contraindication to fluconazole and itraconazole solution. 2. For the treatment of invasive aspergillosis or invasive candidiasis: a. Confirmed diagnosis (Fungal culture and other relevant laboratory studies [including histopathology] must be documented), b. voriconazole will be covered, c. for posaconazole or isavuconazonium: Documented failure, intolerance, or contraindication to voriconazole. 3. For the treatment of blastomycosis or histoplasmosis: itraconazole will be covered, a. For voriconazole or posaconazole: Documented failure, intolerance, or contraindication to itraconazole 4. For prophylaxis of invasive aspergillosis or invasive candidiasis: posaconazole or voriconazole will be covered in severely immunocompromised patients.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	Must be prescribed by, or in consultation with, an infectious disease specialist, hematologist, oncologist, transplant specialist, or pulmonologist for all indication except dermatomycosis.
Coverage Duration	Aspergillus/Candida infection prophylaxis: initial/reauth 1 yr. Other uses: initial 3 mo/reauth 1 yr
Other Criteria	5. For dermatomycosis (itraconazole only): Documentation of trial and failure, intolerance, or contraindication to one topical therapy to treat the condition, or medical rationale for not using a topical agent (e.g., treatment area is large enough or in multiple locations such that it is not practically treated with topical agents). 6. For treatment of mucormycosis: isavuconazonium or posaconazole will be covered. 7. For empiric antifungal therapy in patients with febrile neutropenia: itraconazole, voriconazole or posaconazole will be covered. For reauthorization: Documentation supporting continued use of the requested agent for the intended diagnosis (such as continued active disease, length of therapy is supported by literature or guidelines, for prophylaxis patient continues to be severely immunocompromised).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ANTIPSYCHOTICS

Products Affected

- Aristada
- Caplyta
- Fanapt
- Lybalvi
- Rexulti oral tablet
- Secuado

- Vraylar

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	1. For all requests, documentation of medically accepted diagnosis, defined as Food and Drug Administration (FDA) approved indication or compendia-supported use, AND 2. One of the following indication-specific criteria must be met: a. For adjunctive treatment of major depressive disorder, both of the following must be met: i. Documentation of current use of an antidepressant (e.g., citalopram, sertraline, paroxetine, duloxetine, mirtazapine, venlafaxine) AND ii. Documented trial and failure, intolerance, or contraindication to quetiapine and aripiprazole, b. For schizophrenia: Documented trial and failure, intolerance, or contraindication to two formulary, generic antipsychotics (e.g., quetiapine, olanzapine, ziprasidone, risperidone, aripiprazole, lurasidone), c. For bipolar disorder: Documented trial and failure, intolerance, or contraindication to two formulary, generic medications for bipolar disorder (e.g., lithium, quetiapine, lamotrigine, divalproex, aripiprazole, risperidone, olanzapine, lurasidone).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be approved until no longer eligible with the plan.
Other Criteria	N/A
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Exclusion Criteria	N/A

PA Criteria	Criteria Details
Required Medical Information	For Cryopyrin-Associated Periodic Syndrome (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS), all the following must be met: 1. Diagnosis confirmed by laboratory evidence of genetic mutation NLRP-3 (Nucleotide-binding domain, leucine rich family pyrin domain containing 3) or CIAS1 (Cold-induced autoinflammatory syndrome-1), AND 2. Classic symptoms associated with CAPS (such as urticaria-like rash, fever, cold/stress-triggered episodes, sensorineural hearing loss, chronic aseptic meningitis, and skeletal abnormalities). For Deficiency of Interleukin-1 Receptor Antagonist (DIRA), all the following must be met: 1. Confirmed by laboratory evidence of genetic mutation in IL1RN (encodes for interleukin-1 receptor antagonist), AND 2. Classic symptoms associated with DIRA (such as pustular psoriasis-like rashes, osteomyelitis without bacterial infection, and nail changes), AND 3. Current inflammatory remission of DIRA, AND 4. Weight of at least 10 kg. For recurrent pericarditis, all the following must be met: 1. Diagnosis of recurrent pericarditis (RP) confirmed by an acute episode of pericarditis followed by a 4-6 wee symptom free period prior to the next episode without an identified cause, AND 2. Documentation trial and failure, contraindication or intolerance to NSAIDs or glucocorticoids. Reauthorization requires documentation of improvement of symptoms (such as fever, urticaria-like rash, arthralgia, myalgia, fatigue, and conjunctivitis for CAPS).
Age Restrictions	For CAPS (which includes FCAS, MWS) and RP: Approved for patients 12 years of age and older
Prescriber Restrictions	N/A

PA Criteria	Criteria Details
Coverage Duration	Initial auth will be approved for 6 months. Reauth will be approved for 1 yr.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AURYXIA

Products Affected

- Auryxia

PA Criteria	Criteria Details
Exclusion Criteria	Use for iron deficiency anemia in chronic kidney disease (CKD) not on dialysis
Required Medical Information	For initial authorization of hyperphosphatemia in chronic kidney disease, all the following must be met: 1. Diagnosis of hyperphosphatemia AND 2. Patient has chronic kidney disease (CKD) AND 3. Patient is on dialysis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be approved until no longer eligible with the plan
Other Criteria	
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

BARBITURATES

Products Affected

- phenobarbital oral elixir
- phenobarbital oral tablet 16.2 mg, 30 mg, 32.4 mg, 64.8 mg, 97.2 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	1. Member is less than 65 years of age OR 2. For use for in epilepsy: documented trial, failure, contraindication or intolerance to at least two formulary anticonvulsant agents or medical rationale is provided why formulary anticonvulsants are not indicated. AND for all FDA-approved indications, prescribing provider indicates that medical benefits exceed the risks associated with these medications.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial authorization and reauthorization will be approved for one year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BENLYSTA

Products Affected

- Benlysta subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	1. Severe active central nervous system lupus 2. Current use of other biologic immunomodulator

PA Criteria	Criteria Details
Required Medical Information	For Systemic Lupus Erythematosus (SLE) or active lupus nephritis: All of the following must be met: 1. Documented diagnosis of Systemic Lupus Erythematosus (SLE) or active lupus nephritis by a rheumatologist or nephrologist AND 2. Documentation of laboratory test results indicating that patient has presence of auto-antibodies, defined as one (1) of the following: a. Positive Antinuclear antibody (ANA) b. Positive antidouble-stranded DNA (anti-dsDNA) on two (2) or more occasions, OR if tested by ELISA, an antibody level above laboratory reference range c. Positive anti-Smith (Anti-Sm) d. Positive anti-Ro/SSA and anti-La/SSB antibodies AND 3. Documented failure of an adequate trial of 30-day duration (such as inadequate control with ongoing disease activity and/or frequent flares), contraindication, or intolerance to at least one (1) of the following: a. For SLE without active lupus nephritis: oral corticosteroid(s), azathioprine, methotrexate, mycophenolate mofetil, hydroxychloroquine, chloroquine, or cyclophosphamide, b. For SLE with active lupus nephritis: mycophenolate for induction followed by mycophenolate for maintenance, OR cyclophosphamide for induction followed by azathioprine for maintenance. AND 4. Documentation that patient will continue to receive standard therapy (e.g., corticosteroids, hydroxychloroquine, mycophenolate, azathioprine, methotrexate). Reauthorization: 1. Documentation of positive clinical response to belimumab (e.g. improvement in functional impairment, decrease of corticosteroid dose, decrease in pain medications,
	decrease in the number of exacerbations since prior to start of belimumab, reduction in renal related events) AND 2. Patient currently receiving standard therapy for SLE or active lupus nephritis

PA Criteria	Criteria Details
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, a rheumatologist or nephrologist.
Coverage Duration	Initial authorization and reauthorization will be approved for 6 months.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BUDESONIDE ER

Products Affected

- budesonide oral tablet,delayed and ext.release

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For mild to moderate, active ulcerative colitis: 1. Confirmed diagnosis of mild to moderate, active ulcerative colitis AND 2. Documented trial, failure, intolerance or contraindication to treatment with an aminosalicylate (e.g., sulfasalazine, mesalamine) AND 3. Documented trial, failure, intolerance or contraindication to one of the following oral corticosteroids: dexamethasone, hydrocortisone, methylprednisolone, prednisone or budesonide extended release capsule. For microscopic colitis: 1. Confirmed diagnosis of active, microscopic colitis. Further approval requires medical rationale why additional treatment is warranted for ulcerative colitis and microscopic colitis and if patient is not on maintenance therapy for ulcerative colitis why it is not appropriate.
Age Restrictions	Approved for patients 18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	Initial authorization and reauthorization will be approved for 8 weeks.
Other Criteria	N/A

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Microscopic Colitis
Part B Prerequisite	No

CABLIVI

Products Affected

- Cablivi injection kit

PA Criteria	Criteria Details
Exclusion Criteria	N/A

PA Criteria	Criteria Details
Required Medical Information	Initial Criteria: 1. Diagnosis of acquired thrombotic thrombocytopenic purpura 2. Documentation that therapy will be given in combination with plasma exchange therapy 3. Documentation that therapy will be given in combination with immunosuppressive therapy (i.e., glucocorticoids, rituximab) Reauthorization criteria: If the request is for a new treatment cycle: 1. Documentation of previous positive response to therapy (such as an improvement in platelet counts, reduction in neurological symptoms, or improvements in organ-damage markers) 2. Documentation that therapy will be given in combination with plasma exchange therapy and immunosuppressive therapy (i.e., glucocorticoids, rituximab) 3. Documentation that length of therapy post plasma exchange will not exceed 58 days 4. Documentation that patient has not had more than two recurrences of acquired thrombotic thrombocytopenic purpura while on therapy with caplacizumab. Recurrence is defined as initial platelet normalization followed by a reduction in platelet count that necessitates re-initiation of plasma exchange. If request is for treatment extension: 1. Documentation of positive response to therapy (such as an improvement in platelet counts, reduction in neurological symptoms, or improvements in organ-damage markers) 2. Documentation that patient has signs of persistent underlying disease such as persistent severe ADAMTS13 deficiency 3. Documentation that length of therapy post plasma exchange will not exceed 58 days.
Age Restrictions	Patients 18 years of age and older
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist or hematologist

PA Criteria	Criteria Details
Coverage Duration	Initial authorization and reauthorization will be approved for 90 days.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CAMZYOS

Products Affected

- Camzyos

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	Initial authorization requires documentation of all the following: 1. Clinical diagnosis of obstructive hypertrophic cardiomyopathy (HCM), defined as left ventricular hypertrophy (LVH) in the absence of another cardiac, systemic, or metabolic disease, capable of producing the magnitude of hypertrophy evident, and evidence of one of the following as measured by any imaging technique: a. Left ventricle wall thickness of 15 mm or greater OR b. Left ventricle wall thickness of 13 mm or greater with family history of HCM or in conjunction with a positive genetic test, 2. New York Heart Association (NYHA) class II, III, or IV, 3. Left ventricular ejection fraction (LVEF) 55% or greater, 4. Left ventricular outflow tract (LVOT) peak gradient 50 mmHg or greater at rest or with provocation, and 5. Documented trial and failure, intolerance, or contraindication to two of the following: A. a formulary generic non vasodilating beta blocker (such as propranolol, metoprolol, atenolol, bisoprolol), B. a formulary generic calcium channel blocker (verapamil or diltiazem), C. disopyramide. Reauthorization requires documentation of a positive clinical response, as evidenced by at least one of the following: 1. Improvement in symptoms (such as dyspnea, fatigue, chest pain, palpitations, dizziness, fainting) OR 2. NYHA class reduction.es documentation of all the following: 1. Clinical diagnosis of obstructive hypertrophic cardiomyopathy (HCM), defined as left ventricular hypertrophy (LVH) in the absence of another cardiac, systemic, or metabolic disease, capable of producing the

PA Criteria	Criteria Details
	magnitude of hypertrophy evident, and evidence of one of the following as measured by any imaging technique: a. Left ventricle wall thickness of 15 mm or greater OR b. Left ventricle wall thickness of 13 mm or greater with family history of HCM or in conjunction with a positive genetic test, 2. New York Heart Association (NYHA) class II, III, or IV, 3. Left ventricular ejection fraction (LVEF) 55% or greater,
Age Restrictions	Approved for 18 years of age and older
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist,
Coverage Duration	Initial auth will be approved for six months. Reauth will be approved for one year.
Other Criteria	4. Left ventricular outflow tract (LVOT) peak gradient 50 mmHg or greater at rest or with provocation, and 5. Documented trial and failure, intolerance, or contraindication to all the following: a. A formulary generic non vasodilating beta blocker (such as propranolol, metoprolol, atenolol, bisoprolol) or formulary generic calcium channel blocker (verapamil or diltiazem), AND b. disopyramide. Reauthorization requires documentation of a positive clinical response, as evidenced by at least one of the following: 1. Improvement in symptoms (such as dyspnea, fatigue, chest pain, palpitations, dizziness, fainting) OR 2. NYHA class reduction
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CFTR MODULATORS

Products Affected

- Kalydeco oral granules in packet 13.4 mg, 25 mg, 50 mg, 75 mg
- Kalydeco oral tablet
- Orkambi
- Symdeko
- Trikafta oral granules in packet, sequential
- Trikafta oral tablets, sequential 100-50-75 mg(d) /150 mg (n)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cystic fibrosis with documentation of mutations consistent with FDA approved uses for the requested medication.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by or in consultation with a pulmonologist or provider at a Cystic Fibrosis Center.
Coverage Duration	Authorization will be approved until no longer eligible with the plan
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CGRP-AIMOVIG

Products Affected

- Aimovig Autoinjector

PA Criteria	Criteria Details
Exclusion Criteria	In combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis
Required Medical Information	For initial authorization for prevention of migraine headaches, all the following must be met: 1. Diagnosis of migraine headaches with at least four (4) headache days per month AND 2. One of the following: a. Trial and inadequate response to at least one (1) of the following prophylactic medications: divalproex, valproate, topiramate, metoprolol, propranolol, timolol, amitriptyline, venlafaxine, OR b. Documented intolerance or contraindication to the above medications.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial approval will be for 1 year. Reauth will be approved until no longer eligible with the plan
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

CGRP-EMGALITY

Products Affected

- Emgality Pen
- Emgality Syringe

PA Criteria	Criteria Details
Exclusion Criteria	In combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis
Required Medical Information	For initial authorization for prevention of migraine headaches, all the following must be met: 1. Diagnosis of migraine headaches with at least four (4) headache days per month AND 2. One of the following: a. Trial and inadequate response to at least one (1) of the following prophylactic medications: divalproex, valproate, topiramate, metoprolol, propranolol, timolol, amitriptyline, venlafaxine, OR b. Documented intolerance or contraindication to the above medications. For initiation authorization for cluster headaches, all the following must be met: 1. Diagnosis of episodic cluster headache with at least five (5) cluster headache attacks AND 2. The patient has had at least two cluster periods lasting at least seven (7) days and separated by pain-free remission periods of three months or more. Reauthorization requires clinical benefit with use, such as a reduction in the severity or frequency of headaches.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial approval will be for 1 year. Reauth will be approved until no longer eligible with the plan

PA Criteria	Criteria Details
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CGRP-NURTEC ODT

Products Affected

- Nurtec ODT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial authorization for prevention of migraine headaches, all the following must be met: 1. Diagnosis of migraine headaches with at least four (4) headache days per month AND 2. One of the following: a. Trial and inadequate response to at least one (1) of the following prophylactic medications: divalproex, valproate, topiramate, metoprolol, propranolol, timolol, amitriptyline, venlafaxine, OR b. Documented intolerance or contraindication to the above medications, AND 3.The patient will NOT be using the requested agent in combination with another calcitonin gene-related peptide (CGRP) agent for migraine prophylaxis. For initial authorization for the acute treatment of migraine headaches, all the following criteria must be met: 1. Patient has a diagnosis of migraine with or without aura, AND 2. The patient has tried and had an inadequate response to a triptan (e.g., sumatriptan, rizatriptan) agent, or intolerance, hypersensitivity or an FDA labeled contraindication to a triptan, AND 3. The patient will NOT be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP). Reauthorization requires clinical benefit with use, such as a reduction in the severity or frequency of headaches.

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial approval will be for 1 year. Reauth will be approved until no longer eligible with the plan
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CGRP-UBRELVY

Products Affected

- Ubrelvy

PA Criteria	Criteria Details
Exclusion Criteria	In combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP)
Required Medical Information	For initial authorization for the acute treatment of migraine headaches, all the following criteria must be met: 1. Patient has a diagnosis of migraine with or without aura, AND 2. The patient has tried and had an inadequate response to a triptan (e.g., sumatriptan, rizatriptan) agent, or intolerance, hypersensitivity or an FDA labeled contraindication to a triptan. Reauthorization requires clinical benefit with use, such as a reduction in the severity or frequency of headaches.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial approval will be for 1 year. Reauth will be approved until no longer eligible with the plan
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Corlanor

Products Affected

- Corlanor

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For chronic heart failure in adults, all of the following must be met: 1. Symptoms consistent with New York Heart Association (NYHA) Class II, III, or IV, 2. Left ventricular ejection fraction (LVEF) of 35% or less, 3. Documentation that patient is currently in normal sinus rhythm with resting heart rate of at least 70 bpm, 4. On a maximally tolerated dose of an ACE inhibitor (e.g., lisinopril, enalapril) or ARB (e.g., losartan, valsartan), unless contraindicated or did not tolerate, 5. On a maximally tolerated dose of 1 of the 3 beta-blockers proven to reduce mortality in all stable patients of heart failure with reduced left ventricular ejection fraction (carvedilol, metoprolol succinate, bisoprolol), unless contraindicated or did not tolerate, 6. Documentation that the patient has been hospitalized for worsening heart failure in the previous 12 months. For pediatric patients at least 6 month of age: 1. Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (DCM), 2. Documentation that patient is currently in normal sinus rhythm with resting heart rate as follows: age 6-12 months: at least 105 bpm, age 1-3 years: at least 95 bpm, age 3-5 years: at least 75 bpm, age over 5 years: at least 70 bpm.
Age Restrictions	N/A

PA Criteria	Criteria Details
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist or electrophysiologist.
Coverage Duration	Authorization will be approved until no longer eligible with the plan
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DIACOMIT

Products Affected

- Diacomit

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial authorization, all the following criteria must be met: 1. Documentation of seizures associated with Dravet Syndrome (DS), 2. Documentation of inadequate control on clobazam or valproate, unless contraindicated, 3. Documentation that stiripentol will be used in combination with clobazam 4. Dose will not exceed 50mg/kg (up to maximum 3,000 mg) per day, 5. Baseline absolute neutrophil count (ANC) above 1,900 cells per microliter and platelet count above 150,000 cells per microliter.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, an epilepsy specialist or a neurologist.
Coverage Duration	Authorization will be approved until no longer eligible with the plan.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

DRONABINOL

Products Affected

- dronabinol

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For nausea and vomiting associated with cancer chemotherapy: 1. Documentation of trial and failure, contraindication or intolerance to a 5HT-3 receptor antagonist (e.g., ondansetron). AND 2. Documentation of trial and failure, contraindication or intolerance to one of the following formulary medications unless contraindicated: promethazine, prochlorperazine, chlorpromazine, or metoclopramide. For anorexia with weight loss in patients with AIDS: 1. Documentation that patient is currently taking anti-retroviral therapy AND 2. If patient is less than 65 years of age: Documentation of trial and failure, contraindication, or intolerance to megestrol (Megace)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial authorization and reauthorization will be approved for 6 months.
Other Criteria	N/A
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

DROXIDOPA

Products Affected

- droxidopa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All of the following criteria must be met: 1. Diagnosis of symptomatic neurogenic orthostatic hypotension (nOH) 2. Documentation that neurogenic orthostatic hypotension is caused by one of the following: a. Primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, or pure autonomic failure) b. Dopamine beta-hydroxylase deficiency c. Non-diabetic autonomic neuropathy 3. Documentation of a screen for treatable causes of orthostatic hypotension and currently being treated for the identified treatable cause of orthostatic hypotension 4. Documented trial, failure, intolerance or contraindication to both midodrine and fludrocortisone. Reauthorization: 1. Documented response to initial therapy (improvement in severity from baseline symptoms of dizziness, lightheadedness, feeling faint, or feeling like the patient may black out) 2. Documentation that periodic evaluations are being done to assess continued efficacy and medical rationale for continuing therapy, as none of the clinical trials demonstrated continued efficacy beyond 2 weeks of treatment.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist or neurologist.

PA Criteria	Criteria Details
Coverage Duration	Initial authorization will be for three months. Reauthorization will be approved for 1 year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DUPIXENT

Products Affected

- Dupixent Pen
- Dupixent Syringe

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with another therapeutic immunomodulator agent utilized for the same indication.
Required Medical Information	For initial authorization for moderate-to-severe asthma: 1. Diagnosis of eosinophilic asthma or oral corticosteroid dependent asthma, 2. The patient is currently being treated with, and will continue asthma control therapy in combination with the requested agent, or has an intolerance/ contraindication to standard asthma control therapy. Asthma control therapy may include inhaled corticosteroids (ICS), ICS with long-acting beta agonist (ICS/LABA), leukotriene receptor antagonist (LTRA), long-acting muscarinic antagonist (LAMA), and/or theophylline, 3. Documentation of severe asthma with inadequate control such as frequent exacerbations requiring oral corticosteroids or hospitalizations or a poor asthma control scores (An ACT score less than 20 or an ACQ greater than or equal to 1.5). Reauthorization for asthma requires: 1. Documentation of response to therapy, such as attainment and maintenance of remission or decrease in number of relapses and 2. The patient is currently being treated with, and will continue asthma control therapy in combination with the requested agent, or has an intolerance/ contraindication to standard asthma control therapy (e.g., ICS, ICS/LABA, LRTA, LAMA, theophylline).
Age Restrictions	N/A

PA Criteria	Criteria Details
Prescriber Restrictions	Medications must be prescribed by, or in consultation with the following specialists based on the diagnosis: 1. Asthma: asthma specialist (such as a pulmonologist, immunologist, or allergist), 2. AD: dermatologist, allergist, or immunologist, 3. EOE: allergist or gastroenterologist, 4. CRSwNP: otolaryngologist, allergist, or pulmonologist.
Coverage Duration	AD/PN/EOE/CRSwNP:Initial 6 mo/reauth 1 yr. Asthma:Initial 1yr/reauth until no longer elig with plan

PA Criteria	Criteria Details
Other Criteria	For initial authorization for atopic dermatitis (AD): 1. Diagnosis of moderate to severe atopic dermatitis, 2. Documented inadequate response to one of the following: a. Moderate to high potency topical corticosteroids (e.g., clobetasol 0.05%, betamethasone dipropionate 0.05%, triamcinolone 0.5%) or b. Topical calcineurin inhibitor (e.g., tacrolimus ointment). Reauthorization for AD: Documentation of reduction or stabilization from baseline of flares, pruritus, erythema, edema, xerosis, erosions/excoriations, oozing and crusting, lichenification, or affected BSA. For initial authorization for eosinophilic esophagitis (EoE): 1. Eosinophil-predominant inflammation on esophageal biopsy with greater than or equal to 15 eosinophils per high power field (HPF), 2. Symptoms of esophageal dysfunction such as dysphagia, chest pain, stomach pain, heartburn, regurgitation, and vomiting, 3. Documented trial and failure, contraindication, or hypersensitivity to both of the following treatment modalities: a. Proton pump inhibitors (e.g. omeprazole, pantoprazole) AND b. Topical glucocorticoids (e.g. fluticasone, budesonide). Reauthorization for EoE: Documentation of response to therapy or disease stabilization. For initial authorization for prurigo nodularis (PN): 1. Presence of firm, nodular lesions, 2. Documentation of itching which has lasted for at least six weeks, 3. Patient has had an inadequate response to at least two weeks of moderate to high potency topical corticosteroids (such as clobetasol, betamethasone dipropionate, triamcinolone).

PA Criteria	Criteria Details
	Reauthorization for PN: Documentation of positive clinical response to therapy, such as reduced number of PN nodules and decreased severity of itching. For initial authorization for Chronic Rhinosinusitis with Nasal Polyp (CRSwNP): 1. Evidence of nasal polyposis by direct examination, endoscopy or sinus CT scan and 2. Inadequate response to a three-month trial of intranasal corticosteroids (e.g., fluticasone) or has an intolerance, FDA labeled contraindication, or hypersensitivity to an intranasal corticosteroid. Reauthorization for CRSwNP requires documentation of positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Initial Authorization: 1. Documentation that patient has one of the following: a. Seizures associated with Lennox-Gastaut syndrome (LGS) b. Seizures associated with Dravet syndrome (DS) c. Tuberous sclerosis complex (TSC) 2. Documented trial, failure, intolerance or contraindication to two of the following for the seizure type: a. For DS: clobazam, valproate/ valproic acid or topiramate, b. For LGS: clobazam, lamotrigine, valproate/ valproic acid, topiramate or rufinamide, c. For TSC: clobazam, and valproate/ valproic acid 3. Baseline liver function tests must be documented, 4. Dose will not exceed: a. 20 mg/kg/day in Lennox-Gastaut syndrome or Dravet Syndrome b. 25mg/kg/day in tuberous sclerosis complex
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, an epilepsy specialist or neurologist.
Coverage Duration	Authorization will be approved until no longer eligible with the plan.
Other Criteria	N/A

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ERYTHROPOIESIS STIMULATING AGENTS

Products Affected

- Aranesp (in polysorbate) injection solution 100 mcg/mL, 200 mcg/mL, 25 mcg/mL, 40 mcg/mL, 60 mcg/mL
- Aranesp (in polysorbate) injection syringe
- Epogen injection solution 2,000 unit/mL, 20,000 unit/2 mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL
- Procrit injection solution 10,000 unit/mL, 2,000 unit/mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL, 40,000 unit/mL
- Retacrit

PA Criteria	Criteria Details
Exclusion Criteria	Patients with uncontrolled hypertension, Anemia induced from hepatitis C therapy, Anemia of cancer not related to cancer treatment, Prophylactic use to prevent chemotherapy-induced anemia, Prophylactic use to reduce tumor hypoxia

PA Criteria	Criteria Details
Required Medical Information	1. All diagnoses with the exception of 2d (preoperative use in anemic patients scheduled for elective noncardiac, nonvascular surgery) must have documented hemoglobin (HGB) levels of less than or equal to 10 g/dl or hematocrit (HCT) levels of less than or equal to 30% within 30 days prior to initiation of therapy, AND 2. Must meet the following indication-specific criteria: a. For anemia in Chronic Kidney Disease (not on dialysis): Documentation of adequate iron stores as indicated by current (within the last three months) serum ferritin level greater than or equal to 100 mcg/L or serum transferrin saturation greater than or equal to 20%, b. For anemia due to chemotherapy in cancer and related neoplastic conditions (see exclusion criteria for non-covered indications): i. Adequate iron stores as indicated by current (within the last three months) serum ferritin level more than or equal to 100 mcg/L or serum transferrin saturation more than or equal to 20%, AND, ii. Documentation that anemia is secondary to myelosuppressive chemotherapy in solid tumors, multiple myeloma, lymphoma, or lymphocytic leukemia, c. Anemia associated with zidovudine-treated HIV-infection patients: Documented endogenous serum erythropoietin level less than or equal to 500 mU/ml and zidovudine dose less than or equal to 4200 mg/week.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial authorization and reauthorization will be approved for one year.

PA Criteria	Criteria Details
Other Criteria	d. Preoperative use in anemic patients scheduled for elective hip or knee surgery: i. Documentation of preoperative anemia with pretreatment HGB between 10 and 13 g/dL., ii. The procedure has a high risk of perioperative blood loss (e.g., expected to lose more than 2 units of blood), AND iii. Patient is unwilling or unable to donate autologous blood pre-operatively. e. For anemia secondary to myelodysplastic syndrome (MDS) or myelofibrosis, both of the following criteria must be met: i. Documentation of adequate iron stores as indicated by current (within the last three months) serum ferritin level more than or equal to 100 mcg/L or serum transferrin saturation more than or equal to 20% and ii. Documented current (within last three months) endogenous serum erythropoietin levels less than or equal to 500 mU/mL. Reauthorization requires: 1. Documentation of continued medical necessity AND 2. Documented HGB levels of less than or equal to 12 g/dl within previous 30 days.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ESBRIET/OFEV

Products Affected

- Ofev
- pirfenidone

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	Initial authorization: For Idiopathic Pulmonary Fibrosis (IPF) 1. Diagnosis of Idiopathic Pulmonary Fibrosis a. Note: Confirmed by exclusion of other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, drug toxicity, or connective tissue disease AND 2. Presence of a histological pattern associated with usual interstitial pneumonia (UIP) on high-resolution computed tomography (HRCT) or histological pattern of probable or indeterminate UIP and diagnosis is supported by lung biopsy. For Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) (nintedanib only): 1. Confirmed diagnosis of systemic sclerosis AND 2. Presence of ILD confirmed by evidence of pulmonary fibrosis on HRCT tomography. For other chronic fibrosing interstitial lung diseases with a progressive phenotype (nintedanib only): 1. Presence of ILD confirmed by evidence of pulmonary fibrosis on HRCT tomography AND 2. One (1) of the following criteria: a. Relative decline in FVC of at least 10% of predicted value (as reported by spirometry performed on two different dates within the last two years) b. Relative decline in FVC of at least 5% of predicted value combined with worsening of respiratory symptoms c. Relative decline in FVC of at least 5% of predicted value combined with increased extent of fibrotic changes on chest imaging d. Increased extent of fibrotic changes on chest imaging combined with worsening of respiratory symptoms e. Increased fibrotic changes on HRCT. Reauthorization: Documentation of positive clinical
	response to therapy, such as slowed rate or lack of declining lung function (e.g., FVC, DLCO) and improved or stable respiratory symptoms (e.g., cough, dyspnea).
Age Restrictions	N/A

PA Criteria	Criteria Details
Prescriber Restrictions	For SSc-ILD only: Must be prescribed by or in consultation with a pulmonologist or rheumatologist. For all other indications: Must be prescribed by or in consultation with a pulmonologist
Coverage Duration	Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FINTEPLA

Products Affected

- Fintepla

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of, or within 14 days of administration of monoamine oxidase inhibitors because of an increased risk of serotonin syndrome
Required Medical Information	Initial authorization: 1. Documentation that patient has seizures associated with Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS) AND 2. Documented trial, failure, intolerance or contraindication to one of the following: valproate/valproic acid, clobazam, or topiramate.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, an epilepsy specialist or neurologist.
Coverage Duration	Authorization will be approved until no longer eligible with the plan
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FIRDAPSE

Products Affected

- Firdapse

PA Criteria	Criteria Details
Exclusion Criteria	Patients with a history of seizures
Required Medical Information	For initial authorization, all the following must be met: 1. Confirmed diagnosis of Lambert-Eaton myasthenic syndrome (LEMS), 2. Documentation of confirmatory diagnostic test results including: a. Repetitive Nerve Stimulation (RNS) testing showing reproducible post-exercise increase in compound muscle action potential (CMAP) amplitude of at least 60 percent compared with pre-exercise baseline value or a similar increment on high-frequency repetitive nerve stimulation without exercise OR b. Positive anti-P/Q type voltage-gated calcium channel antibody test, 3.Documentation of symptomatic disease, such as dyspnea or muscle weakness, 4. Member has been evaluated for malignancy and treated for malignancy, if present. Note: LEMS symptoms associated with malignancy may resolve after treatment directed at malignancy. Reauthorization requires documentation of improvement or stabilization of muscle weakness from baseline.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, a neurologist

PA Criteria	Criteria Details
Coverage Duration	Initial approval will be approved for 3 months. Reauthorization will be approved for 12 months.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GATTEX

Products Affected

- Gattex 30-Vial
- Gattex One-Vial

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For initiation of therapy in short bowel syndrome (SBS), all the following must be met: 1. An initial nutritional assessment has been completed by a registered dietitian who has determined that oral/enteral nutrition is not sufficient to meet nutritional goals, AND 2. Patient is stable and dependent on parenteral support (fluids, electrolytes and/or nutrients) delivered at least three times per week, AND 3. The medication has been made part of a treatment plan established by a gastroenterologist or a hospital Metabolic Support Team that includes: a. Member evaluation indicates the possibility of success with treatment b. Defined parameters to measure response to therapy, AND 4. Dose does not exceed 0.05 mg/kg once daily. For patients already established on therapy, the following must be met: Documentation that parenteral nutrition support requirement has decreased since initiation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, a gastroenterologist.

PA Criteria	Criteria Details
Coverage Duration	Initial approval will be approved for 6 months. Reauthorization will be approved for 12 months.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GLP-1 AGONISTS

Products Affected

- Bydureon BCise
- Mounjaro
- Ozempic subcutaneous pen injector 0.25 mg or 0.5 mg (2 mg/3 mL), 1 mg/dose (4 mg/3 mL), 2 mg/dose (8 mg/3 mL)
- Rybelsus
- Trulicity
- Victoza 2-Pak
- Victoza 3-Pak

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All the following must be met: 1. The requested agent will NOT be used for weight loss alone, AND 2. The patient has a diagnosis of type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be approved until no longer eligible with the plan.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HEPATITIS C

Products Affected

- ledipasvir-sofosbuvir
- Mavyret
- sofosbuvir-velpatasvir
- Vosevi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current American Association for the Study of Liver Diseases (AASLD)/Infectious Diseases Society of America (IDSA) guidance.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease specialist, or providers experienced in Hepatitis C management.
Coverage Duration	8 to 24 weeks based on medication, indication and established treatment guidelines
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HEREDITARY ANGIOEDEMA THERAPY

Products Affected

- Cinryze
- Haegarda
- icatibant
- Orladeyo
- Sajazir
- Takhzyro

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of more than one agent used for prophylaxis
Required Medical Information	All of the following must be met: 1. Diagnosis of Hereditary Angioedema (HAE) Type I, II or III, 2. One of the following: a. For HAE Type I and Type II, documentation of a complement study that shows: i. C4 less than normal AND ii. One of the following: C1-Inhibitor (C1-INH) protein or C1-INH function less than normal. b. For HAE with normal C1-INH or HAE Type III, one of the following: i. Confirmed Factor 12 (FXII) ANGPT1, PLG, KNG1 gene mutation OR ii. Positive family history for HAE and attacks that lack response to high dose antihistamines or corticosteroids, and 3. Dosing regimens are within FDA labeled dosing outlined in package insert or sufficient evidence-based rationale is provided for increased dosing and/or frequency. 4. For coverage of Cinryze: Documentation of trial and failure or contraindication to Haegarda. Reauthorization requires documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, an immunologist or allergist.
Coverage Duration	Initial prior authorization will be approved for 3 months. Reauthorization may be approved for 1 yr.

PA Criteria	Criteria Details
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HETLIOZ

Products Affected

- Hetlioz LQ
- tasimelteon

PA Criteria	Criteria Details
Exclusion Criteria	Sleep disorders other than Non-24 and nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)
Required Medical Information	For Non-24-Hour Sleep-Wake Disorder (Non-24): All of the following criteria must be met: 1. Member is totally blind (i.e. no light perception), 2. Documented diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24), as characterized by all of the following: a. Distinct pattern of sleeping and waking that drifts by a consistent time period every night AND b. History of periods of insomnia, excessive sleepiness, or both, which alternate with short asymptomatic periods, 3. Documented sleep study to exclude other sleep disorders. Reauthorization requires documentation of entrainment to the 24-hour circadian period. For nighttime sleep disturbances in Smith-Magenis Syndrome (SMS): All of the following criteria must be met: 1. Documented diagnosis of SMS, as characterized by: a. Confirmation of the deletion or mutations of retinoic acid-induced 1 (RAI1) gene, 2. Documented sleep study to exclude other sleep disorders, 3. Documentation of at least one of the following: a. difficulties falling asleep, b. shortened sleep cycles, c. frequent and prolonged nocturnal awakenings, d. excessive daytime sleepiness or e. daytime napping. Reauthorization requires documentation of improvement in sleep quality or total sleep time.
Age Restrictions	N/A

PA Criteria	Criteria Details
Prescriber Restrictions	Must be prescribed by or in consultation with a sleep specialist or neurologist.
Coverage Duration	Initial auth will be approved for 6 months. Reauth will be approved for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HUMAN GROWTH HORMONES

Products Affected

- Omnitrope

PA Criteria	Criteria Details
Exclusion Criteria	N/A

PA Criteria	Criteria Details
Required Medical Information	For initial authorization for Growth Hormone Deficiency (GHD) in adults due to congenital defects, genetic defects, organic hypothalamic-pituitary disease, must meet one of the following criteria: 1. At least three pituitary hormone deficiencies (other than GH) or 2. Less than three pituitary hormone deficiencies, or IGF-1 below normal for age/sex, and one of the following confirmatory stimulation tests: a. Insulin Tolerance Test (ITT) with peak GH less than/equal to 5 micrograms per liter (mcg/L), b. Glucagon Stimulation Test (GST) with low peak GH based on body mass index (BMI), as follows: i. BMI less than 25: Peak GH less than/equal to 3 mcg/L, ii. BMI 25-30: Peak GH less than/equal to 1 mcg/L (patients with high clinical suspicion of GHD, peak GH less than 3 mcg/L will be covered), iii. BMI greater than/equal to 30: Peak GH less than/equal to 1 mcg/L, c. Macimorelin with peak GH less than/equal to 2.8 mcg/L. For initial authorization for GHD in adults (adult-onset) and history of destructive lesions of the hypothalamic region (such as hypothalamic-pituitary tumors, surgery, cranial irradiation, traumatic brain injury): 1. IGF-1 below normal for age/sex, 2. One of the following confirmatory stimulation tests: a. Insulin Tolerance Test (ITT) with peak GH less than/equal to 5 mcg/L, b. Glucagon Stimulation Test (GST) with low peak GH based on body mass index (BMI), as follows: i. BMI less than 25: Peak GH less than/equal to 3 mcg/L, ii. BMI 25-30: Peak GH less than/equal to 1 mcg/L. For patients with high clinical suspicion of GHD in this range, coverage will be approved with peak GH less than 3

PA Criteria	Criteria Details
	mcg/L., iii. BMI greater than/equal to 30: Peak GH less than/equal to 1 mcg/L, c. Macimorelin with peak GH less than/equal to 2.8 mcg/L. For reauthorization for GHD in adults: evidence of improved quality of life, good tolerability, and annual documentation of IGF-1 with appropriate dosage adjustments (GH requirements often decrease with age).
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by or in consultation with an endocrinologist.
Coverage Duration	SBS: 4 weeks. AIDS wasting: 12 months. All other uses: initial/reauth for 12 months.

PA Criteria	Criteria Details
Other Criteria	For initial authorization for GHD in children, must meet one of the following: 1. Newborn with hypoglycemia and both of the following: a. Serum GH level less than/equal to 5 mcg/L and b. One of the following: i. An additional pituitary hormone deficiency (other than GH), or ii. Classical imaging triad (ectopic posterior pituitary and pituitary hypoplasia with abnormal stalk), 2. Extreme short stature (height more than 3 SDS below the mean for chronological age/sex), all the following: a. IGF-1 level at least 2 SDS below normal, b. Insulin-like growth factor binding protein-3 (IGFBP-3) at least 2 SDS below normal, or c. Delayed bone age (2 SDs below the mean for chronological age), 3. Pituitary abnormality (secondary to a congenital anomaly, tumor, or irradiation) and both of the following criteria: a. Additional pituitary hormone deficiency (other than GH), and b. Evidence of short stature/growth failure (GF) by one of the following: i. Height more than 3 SDS below the mean for chronological age/sex, ii. Height below 3rd percentile (or greater than 2 SD below the mean) AND untreated growth velocity (GV) is below the 25th percentile, iii. Severe growth rate deceleration (GV over one year of more than 2 SD below the mean for age/sex), 4. Suspected GHD and all the following: a. Evidence of short stature/GF using criteria above, b. Biochemical GHD by one of the following: i. Two GH stimulation tests (using arginine, clonidine, glucagon, insulin, or levodopa) with peak GH concentrations less than 10 ng/mL or ii. One GH stim test with peak GH less than 15 ng/ml and

PA Criteria	Criteria Details
	IGF-1 and IGFBP-3 levels below normal. For Prader-Willi Syndrome, Turner Syndrome, Short stature homeobox-containing (SHOX) deficiency: 1. Confirmed diagnosis by genetic testing and 2. Evidence of short stature/GF using criteria above. For Noonan Syndrome: 1. Confirmed diagnosis by genetic testing or made by an endocrinologist based on clinical features AND 2. Evidence of short stature/GF using criteria above. For GF due to chronic kidney disease: 1. Other causes of GF have been ruled out, AND 2. Evidence of short stature/GF using criteria above. For Small for Gestational Age: 1. Birth weight or length at least 2 SDs below the mean AND 2. Failure to reach catch-up growth by two years of age (height at least two SDS below the mean for age/sex). For Reauthorization for children (all diagnoses): 1. Evidence of improved growth AND 2. Evidence of open epiphyses
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INCRELEX

Products Affected

- Increlex

PA Criteria	Criteria Details
Exclusion Criteria	Subjects with secondary forms of IGF-1 deficiency (e.g., GH deficiency, malnutrition, hypothyroidism, chronic treatment with pharmacologic doses of anti-inflammatory steroids) Concurrent use of growth hormone therapy. Malignant neoplasia
Required Medical Information	For severe primary IGF-1 deficiency all of the following criteria must be met: 1. Height standard deviation score of less than or equal to -3.0, 2. Basal IGF-1 standard deviation score of less than or equal to -3.0, 3. Normal or elevated growth hormone (GH) levels, AND 4. Documentation of open epiphyses by bone radiograph. For GH gene deletion: 1. Documentation of open epiphyses by bone radiograph AND 2. Patient has developed neutralizing antibodies to growth hormone. Reauthorization will require evidence that the medication remains effective, growth velocity is above 2.0 cm/year, evidence of open epiphyses, and documentation of expected adult height goal that is not yet obtained.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial authorization and reauthorization will be approved for one year.

PA Criteria	Criteria Details
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ISTURISA/SIGNIFOR

Products Affected

- Isturisa
- Signifor

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For initial authorization all of the following criteria must be met: 1. Diagnosis of endogenous Cushings Disease AND 2. Documentation of one of the following: a. Patient has failed pituitary surgery OR b. Patient is not a candidate for surgery. Reauthorization requires documentation of positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease).
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial authorization and reauthorization will be approved for one year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of Heterozygous familial hypercholesterolemia or other hyperlipidemia disorders

PA Criteria	Criteria Details
Required Medical Information	For initial authorization, all the following must be met: 1. Diagnosis of Homozygous Familial Hypercholesterolemia (HoFH) as evidenced by either genetic or clinical confirmation, as outlined below: a. Genetic confirmation: biallelic functional mutations in the low density lipoprotein receptor (LDLR), apolipoprotein B (apo B), proprotein convertase subtilisin/kexin type 9 (PCSK9) or LDL receptor adapter protein 1 (LDLRAP1) genes, b. Clinical confirmation defined as untreated total cholesterol greater than 500 mg/dL or treated LDL-C greater than or equal to 300 mg/dL and one of the following: i. Presence of xanthomas before the age of 10 years, or ii. Evidence of heterozygous familial hypercholesterolemia in both parents such as documented history of elevated LDL-C greater than or equal to 190 mg/dL prior to lipid-lowering therapy, AND 2. Current use of TWO (2) of the following therapies: a. High-intensity statin therapy, defined as atorvastatin 40-80 mg daily or rosuvastatin 20-40 mg daily, unless contraindicated or documented statin intolerance, b. Ezetimibe, unless contraindicated or prior intolerance, c.PCSK-9 inhibitor (such as, evolocumab), unless contraindicated or prior intolerance, AND 3. Documentation of LDL cholesterol levels (taken within the last six months) of greater than 100 mg/dL despite at least six (6) months of use of the therapies outlined above. Initial reauthorization requires documentation of at least a 30% reduction in LDL cholesterol levels from pre-treatment levels.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or board certified lipidologist.
Coverage Duration	Initial auth approved for 1 year. Reauth will be approved until no longer eligible with the plan.

PA Criteria	Criteria Details
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

KERENDIA

Products Affected

- Kerendia

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For initiation of therapy, all the following must be met: 1. Patient has a diagnosis of type 2 diabetes, AND 2. Patient has evidence of diabetic nephropathy, AND 3. Documentation that patient is on a maximally tolerated Angiotensin Converting Enzyme inhibitor (such as lisinopril) or an Angiotensin Receptor Blocker (such as losartan), unless all agents in these classes are contraindicated, AND 4. Documentation of trial, contraindication, or intolerance to a Sodium Glucose Co-transporter-2 inhibitor (such as empagliflozin or dapagliflozin).
Age Restrictions	Approved for patients 18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be approved until no longer eligible with the plan.
Other Criteria	
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Exclusion Criteria	Current pregnancy
Required Medical Information	Initial authorization: 1. Documentation that the patient has hyperglycemia secondary to endogenous Cushings Syndrome (defined as hypercortisolism that is not a result of chronic administration of high dose glucocorticoids), AND 2. Documentation that the patient has type 2 diabetes mellitus or glucose intolerance, AND 3. Documentation that the patient has failed surgery or is not a candidate for surgery. Reauthorization: Documentation that the patient has improved or stable glucose tolerance.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, an endocrinologist.
Coverage Duration	Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

LIDODERM

Products Affected

- lidocaine topical adhesive patch,medicated 5 %
- Lidoderm

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Confirmed diagnosis of post-herpetic neuralgia, cancer-related neuropathic pain, or diabetic peripheral neuropathy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be approved until no longer eligible with the plan
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Diabetic peripheral neuropathy and cancer-related neuropathic pain.
Part B Prerequisite	No

MULTIPLE SCLEROSIS DRUGS

Products Affected

- Extavia
- Zeposia
- Zeposia Starter Kit (28-day)
- Zeposia Starter Pack (7-day)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For initiation of treatment cardiac evaluation, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist or gastroenterologist
Coverage Duration	Initial authorization for 6 months and reauthorization will be approved for 1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MUSCULOSKELETAL DRUGS

Products Affected

- cyclobenzaprine oral tablet 10 mg, 750 mg 5 mg
- methocarbamol oral tablet 500 mg,

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Member is under 65 years old OR 2. If over 65 years: a. Documentation that the risks of the medications (CNS depression) have been discussed with the patient, including that these risks increase with age. AND b. Documentation that the provider feels this medications is appropriate for the patient's age despite the risks outlined above. Reauthorization requires: 1. Documentation that the patient is responding well to therapy without side effects AND 2. If over 65 years, documentation that the risks of the medication have been discussed at least annually with the patient and the provider and the patient both feel continuation of therapy is medically necessary despite risks.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial auth will be approved for 3 months. Reauth will be approved for one year.
Other Criteria	N/A
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

NEXLETOL/NEXLIZET

Products Affected

- Nexletol
- Nexlizet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For Initial Authorization, all of the following must be met: 1. Confirmed diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) or familial hypercholesterolemia, 2. Fasting LDL-C greater than or equal to 70 mg/dL despite treatment with therapies below, 3. One of the following: a. Current use of high-intensity statin therapy for at least 3 months, defined as atorvastatin 80 mg daily or rosuvastatin 40 mg daily or b. Documented intolerance, FDA labeled contraindication or hypersensitivity to a statin, 4. Current use of a formulary PCSK-9 inhibitor (such as Repatha) for at least three (3) months, or documented intolerance/contraindication to its use. Reauthorization requires documented response to therapy, as defined by a reduction in fasting LDL-C.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial auth approved for one year. Reauth will be approved until no longer eligible with the plan.
Other Criteria	N/A

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Exclusion Criteria	Current use, or use within the past 14 days, of monoamine oxidase inhibitors (MAOIs) and patients diagnosed with a prolonged QT interval, congenital long QT syndrome, or a history suggesting torsades de pointes.
Required Medical Information	Initial authorization: 1. Diagnosis of pseudobulbar affect (PBA) AND 2. Documentation of a neurologic disease or brain injury (such as traumatic brain injury, stroke, dementia, multiple sclerosis, amyotrophic lateral sclerosis [ALS], or Parkinsons disease). Reauthorization: Documentation of response to therapy, defined as a reduction in episodes of laughing, crying, and/or emotional lability.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial authorization and reauthorization will be approved for one year.
Other Criteria	N/A
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For initial authorization, all the following must be met: 1. Diagnosis of Parkinsons disease with hallucinations and/or delusions causing clinically significant distress, with dementia-related psychosis ruled out AND 2. Patient able to self-report symptoms (such as hallucinations or distress) AND 3. Documented trial and failure, intolerance, or contraindication to clozapine.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, a neurologist, psychiatrist, or geriatrician.
Coverage Duration	Authorization will be approved until no longer eligible with the plan.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OCALIVA

Products Affected

- Ocaliva

PA Criteria	Criteria Details
Exclusion Criteria	Non-alcoholic steatohepatitis (NASH). Decompensated cirrhosis (such as Child-Pugh Class B or C) or a prior decompensated event. Compensated cirrhosis with evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia)
Required Medical Information	For the diagnosis of primary biliary cholangitis, all the following must be met: 1. Confirmed diagnosis of primary biliary cholangitis as evidenced by two (2) of the following criteria: a. Elevated alkaline phosphatase (ALP) [above the upper limit of normal (ULN) as defined by laboratory reference values] b. Presence of antimitochondrial antibody (AMA) c. Histologic evidence of primary biliary cirrhosis from liver biopsy AND 2. Both of the following: a. Use of ursodiol for a minimum of 12 months and has had an inadequate response according to prescribing physician AND b. Documentation that the medication will be used in combination with ursodiol, unless patient is unable to tolerate ursodiol. Reauthorization criteria, all the following must be met: 1. Maintenance of biochemical response (e.g. improvement or stabilization of ALP or total bilirubin levels) 2. Documentation that ursodiol will be continued, if tolerated 3. Hepatic function is assessed at least annually.
Age Restrictions	N/A

PA Criteria	Criteria Details
Prescriber Restrictions	Must be prescribed by, or in consultation with, a gastroenterologist or hepatologist.
Coverage Duration	Initial authorization will be approved for 4 months. Reauthorization will be approved for one year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ORENCIA

Products Affected

- Orencia
- Orencia ClickJect

PA Criteria	Criteria Details
Exclusion Criteria	Patient is currently being treated with another therapeutic immunomodulator or apremilast

PA Criteria	Criteria Details
Required Medical Information	For patients already established on the requested therapy: 1. Documentation of response to therapy (i.e. slowing of disease progression or decrease in symptom severity and/or frequency) and 2. One of the following: a. Patient is not currently being treated with another biologic immunomodulator OR b. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator. For patients being initiated on therapy, all of the following criteria must be met: 1. Patient must have an FDA labeled indication for the requested agent, 2. One of the following: a. Patient is not currently being treated with another biologic immunomodulator OR b. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent, 3. Documentation of trial and failure, intolerance, or contraindication to preferred biologic agents, as follows: Use of TWO preferred agents (secukinumab, etanercept, adalimumab, upadacitinib, risankizumab, ustekinumab, tofactinib) is required for diagnosis of psoriatic arthritis. Use of TWO preferred agents (etanercept, adalimumab, upadacitinib, tofacitinib) is required for diagnosis of rheumatoid arthritis. Use of TWO preferred agents (etanercept, adalimumab, tofacitinib) is required for diagnosis of juvenile idiopathic arthritis. NO preferred agent is required for diagnosis of prophylaxis of acute graft vs host disease.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, a dermatologist, rheumatologist, or transplant specialist.
Coverage Duration	Initial authorization and reauthorization will be approved for one year.

PA Criteria	Criteria Details
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OSMOLEX ER

Products Affected

- Osmolex ER oral tablet, IR - ER, biphasic 24hr 129 mg, 193 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Initial authorization: 1. Documentation of one of the following: a. Diagnosis of Parkinsons Disease or b. Diagnosis of drug-induced extrapyramidal symptoms, AND 2. Documented trial and failure of immediate release amantadine of a dose of at least 300 mg daily unless intolerable side effects at lower doses. Reauthorization requires documentation of successful response to the medication.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist, psychiatrist or expert in the treatment of movement disorders
Coverage Duration	Authorization will be approved until no longer eligible with the plan
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

OSTEOANABOLIC AGENTS

Products Affected

- teriparatide
- Tymlos

PA Criteria	Criteria Details
Exclusion Criteria	N/A

PA Criteria	Criteria Details
Required Medical Information	For the treatment or prevention of osteoporosis, must meet ONE of the following criteria (a-e): a. Patient has a history of multiple or severe vertebral fractures, or history of fragility fractures, b. Patient has a spine or hip bone mineral density (BMD) T-score less than or equal to -3.0, c. Patient has a spine or hip bone mineral density (BMD) T-score less than or equal to -2.5 to -3.0 and high risk for fracture, defined as one of the following: i. Age more than 80 years, ii. Chronic glucocorticoid use, iii. Documented increased fall risk, d. Patient has a spine or hip BMD T-score less than or equal to -2.5 to -3.0 and one of the following: 1. Documented failure to anti-resorptive therapy (e.g., denosumab, bisphosphonates). Failure is defined as a new fracture or worsening BMD while on therapy, or 2. Documented contraindication or intolerance to both denosumab and bisphosphonate therapies, OR e. Patient has a spine or hip BMD T-score between -1.0 and -2.5 and BOTH of the following (i. and ii.): i. Fracture Risk Assessment (FRAX) probability score for hip fracture of at least 3% or, for other major osteoporosis fracture, of at least 20%, ii. One of the following: 1. Documented failure to anti-resorptive therapy (e.g., denosumab, bisphosphonates). Failure is defined as a new fracture or worsening BMD while on therapy, 2. Documented contraindication or intolerance to both denosumab and bisphosphonate therapies
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, an endocrinologist or rheumatologist
Coverage Duration	Auth for up to 2 yrs in lifetime. No reauth, unless meets clinical criteria for teriparatide

PA Criteria	Criteria Details
Other Criteria	For authorization for teriparatide use exceeding two years in a lifetime, must meet both of the following criteria: 1. Documentation that previous treatment with teriparatide showed clinical improvement, defined as absence/decrease in frequency of new fragility fracture or stable/increased BMD T-score while on teriparatide 2. One of the following: a. Patient continues to be at very high risk for fracture, defined as one of the following while on teriparatide: i. BMD T-score continues to be less than or equal to -3.0 ii. New vertebral or fragility fracture b. Documentation of worsening disease, defined as one of the following: i. A repeat BMD after discontinuation of therapy demonstrates a decline in BMD ii. New onset fragility fracture after discontinuation
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes

PCSK-9 INHIBITORS

Products Affected

- Repatha Pushtronex
- Repatha SureClick
- Repatha Syringe

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with another PCSK9 inhibitor.

PA Criteria	Criteria Details
Required Medical Information	For initial authorization, both criteria 1 and 2 must be met: 1. One of the following: a. The patient has an inadequate response to a high-intensity statin (rosuvastatin 20-40 mg or atorvastatin 40-80 mg), b. The patient has an intolerance to TWO different statins, or c. The patient has an FDA labeled contraindication to a statin, AND 2. Must meet listed criteria below for each specific diagnosis: a. Diagnosis of familial hypercholesterolemia and one of the following: i. Genetic confirmation of a mutation at the LDLR, Apo-B, PCSK9, or 1/LDLRAP1 gene, ii. History of LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) (pretreatment), iii. The patient has clinical manifestations of familial hypercholesterolemia (such as cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthoma, or xanthelasma), iv. The patient has definite or possible familial hypercholesterolemia as defined by the Simon Broome criteria, v. The patient has a Dutch Lipid Clinic Network criteria score of greater than 5, vi. The patient has a treated low-density lipoprotein cholesterol (LDL-C) level 100 mg/dL or greater after treatment with antihyperlipidemic agents but prior to PCSK9 inhibitor therapy, b. Diagnosis of established cardiovascular disease [angina pectoris, coronary heart disease, myocardial infarction, transient ischemic attacks, cerebrovascular disease, peripheral vascular disease (PVD), history of coronary revascularization or carotid endarterectomy] AND the requested agent will be used to reduce the risk of myocardial infarction, stroke, and coronary revascularization, OR c. A diagnosis of primary
	hyperlipidemia (not associated with familial hypercholesterolemia or established cardiovascular disease). Reauthorization requires provider attestation of response to therapy, defined as a decrease in LDL-C levels from pre-treatment levels.

PA Criteria	Criteria Details
Age Restrictions	N/A
Prescriber Restrictions	Medications must be prescribed by, or in consultation with a cardiologist, endocrinologist, and/or a physician who focuses in the treatment of cardiovascular risk management and/or lipid disorders
Coverage Duration	Initial auth for one year. Reauth will be approved until no longer eligible with plan.
Other Criteria	Secondary causes may include hypothyroidism, nephrosis, or extreme dietary patterns, OR iv. Presence of xanthomas, b. For ASCVD, attestation of LDL-C greater than or equal to 70 mg/dL and history of clinical ASCVD, defined as one of the following: i. Acute coronary syndromes ii. History of myocardial infarction iii. Stable/unstable angina iv. Coronary or other arterial revascularization v. Stroke or transient ischemic attack vi. Peripheral artery disease presumed to be of atherosclerotic origin vii. Clinically significant multi-vessel coronary heart disease presumed to be of atherosclerotic origin. Initial Reauthorization: Provider attestation of response to therapy, defined as a decrease in LDL-C levels from pre-treatment levels.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PREVYMIS

Products Affected

- Prevymis oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	One of the following criteria must be met: 1. Patient is using for prophylaxis of cytomegalovirus (CMV) infection after allogeneic hematopoietic stem cell transplant (HSCT) and all of the following: a. Patient is CMV seropositive and b. Attestation that therapy will be started within 28 days post-transplantation, or 2. Patient is using for prophylaxis of CMV disease after kidney transplant and all of the following: a. Patient is at high risk, defined as CMV seropositive Donor in a Recipient that is CMV seronegative (D+/R-) and b. Attestation that therapy will be started within seven (7) days post-transplantation.
Age Restrictions	Approved for patients 18 years of age and older
Prescriber Restrictions	Must be prescribed by, or in consultation with, a hematologist, oncologist, transplant specialist, or infectious disease specialist.
Coverage Duration	Authorization will be approved for up to 200 days post-transplantation.
Other Criteria	N/A
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

PROLIA

Products Affected

- Prolia

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For the treatment or prevention of osteoporosis: 1. Documentation of trial and failure of bisphosphonate therapy or contraindication/intolerance to both oral and IV bisphosphonate therapy, AND 2. One of the following criteria: A. Documented clinical diagnosis of osteoporosis [defined as a non-traumatic, non-pathologic spinal fracture OR spine, femoral neck or hip bone mineral density (BMD) T-score less than or equal to -2.5]. OR B. Documented risk of osteoporosis (defined as BMD T-score between -1.0 and 2.5) AND meeting one of two risk assessments a) one of the following risk factors: i. previous fracture, ii. history of hip or spine fracture in first degree relative, iii. low body weight (less than 127 lbs. for women), iv. smoking, excess alcohol intake, v. secondary osteoporosis (e.g. rheumatoid arthritis), vi. history of falls, b) FRAX Hip fracture probability greater than or equal to 3% or other major osteoporosis fracture probability greater than or equal to 20% OR C. One of the following chronic glucocorticosteroid use: a) greater than 20 mg/day for longer than 1 month b) 5-20 mg/day for longer than 3 months in post menopausal women not on estrogen c) 5-20 mg/day for longer than 3 months AND T-score less than -1.5.
Age Restrictions	N/A

PA Criteria	Criteria Details
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be approved until no longer eligible with the plan.
Other Criteria	Part B before Part D Step Therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For initiation of therapy, must meet the following indication-specific criteria: 1. For myelodysplastic syndromes (MDS): use must be for an FDA approved indication or indication supported by National Comprehensive Cancer Network guidelines with recommendation 2A or higher, 2. For Immune Thrombocytopenia (ITP), all the following criteria (a-c) must be met: a. Diagnosis of chronic immune thrombocytopenia (ITP), b. Platelet count of less than 30,000 cells per microliter, AND c. Treatment with at least one of the following therapies was ineffective or not tolerated, unless all are contraindicated: i. Systemic corticosteroids, ii. Immune globulin, iii. Splenectomy, iv. Rituximab, 3. For Severe Aplastic Anemia, documentation that the patient is at risk for bleeding with a platelet count of less than 30,000 cells per microliter, 4. Thrombocytopenia due to chronic Hepatitis C. For patients established on therapy, must meet indication-specific criteria below: 1. For MDS: documentation of improved platelet levels from baseline, 2. For ITP, severe aplastic anemia or Hepatitis C: a. Documentation of improved platelet levels from baseline AND b. Documentation the continued therapy is medically necessary to maintain a platelet count of at least 50,000 cells per microliter.

PA Criteria	Criteria Details
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with an oncologist, hematologist, infectious disease specialist, gastroenterologist, or hepatologist.
Coverage Duration	Initial authorization will be approved for 6 months. Reauthorization will be approved for 12 months.
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Myelodysplastic syndromes
Part B Prerequisite	No

PULMONARY ANTIHYPERTENSIVES

Products Affected

- Adempas
- Alyq
- ambrisentan
- bosentan
- Opsumit
- Orenitram
- sildenafil (pulm.hypertension) oral tablet
- tadalafil (pulm. hypertension)
- Tracleer oral tablet for suspension
- Uptravi oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For initial authorization the following criteria must be documented: 1. Diagnosis of Pulmonary Hypertension (PH) confirmed by right heart catheterization, as defined by all of the following: a. Mean pulmonary artery pressure (mPAP) greater than or equal to 20 mmHg at rest, b. Pulmonary capillary wedge pressure (PCWP) or left ventricular end diastolic pressure (LVEDP) less than or equal to 15 mmHg, AND c. Pulmonary vascular resistance (PVR) greater than 3 Wood units (WU), 2. Patient has documentation of one of the following i. World Health Organization (WHO) Group 1 classification PAH (or WHO Group 4 classification CTEPH for Adempas only) with WHO/New York Heart Association (NYHA) functional class II, III, or IV, ii. For Tyvaso DPI only, pulmonary hypertension associated with interstitial lung disease (WHO Group 3 classification PH-ILD). 3. For Opsumit, Uptravi, Tracleer tablets for suspension, patient has had a therapeutic failure to generic bosentan or ambrisentan. Reauthorization requires documentation of response to therapy including lack of disease progression or improvement in WHO functional class.

PA Criteria	Criteria Details
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, a pulmonologist or cardiologist
Coverage Duration	Authorization will be approved until no longer eligible with the plan.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RADICAVA

Products Affected

- Radicava ORS
- Radicava ORS Starter Kit Susp

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. For initiation of therapy, all of the following criteria must be met: a. Documentation of definite or probable amyotrophic lateral sclerosis (ALS) within the previous two years per the El Escorial (Airlie House) Criteria b. Documentation of baseline ALS Functional Rating Scale-Revised (ALSFRS-R) with at least 2 points in each individual item c. Forced vital capacity (FVC) of at least 80% (taken within the past three months) d. Dosing is in accordance with the FDA approved labeling 2. For patients established on therapy: a. Documentation of a clinical benefit from therapy such as slowing of disease progression or stabilization of functional ability and maintenance of activities of daily living (ADLs) b. Dosing is in accordance with the FDA approved labeling.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, a neurologist with expertise in ALS.
Coverage Duration	Initial authorization will be approved for six months. Reauthorization will be approved for one year
Other Criteria	

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For initial authorization, all the following must be met: 1. Documentation of lower extremity diabetic neuropathic ulcer, AND 2. Documentation that treatment will be given in combination with standard ulcer care (such as debridement, adequate nutritional status, infection control). There is no medical evidence to justify ongoing treatment after 180 days.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be approved for 6 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RELISTOR

Products Affected

- Relistor oral
- Relistor subcutaneous solution
- Relistor subcutaneous syringe

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For initial authorization all of the following criteria must be met: 1. Patient is on chronic opioid therapy, AND 2. Documentation of less than three (3) spontaneous bowel movements per week, AND 3. Documentation of trial and failure (at least two weeks of therapy), intolerance, or contraindication to routine laxative therapy with lactulose, AND 4. One of the following: A. Opioid-induced constipation in adult patients with advanced illness, OR B. For opioid-induced constipation in patients with chronic noncancer pain, documentation of trial and failure (at least two weeks of therapy), intolerance, or contraindication to one of the following: a. naloxegol (Movantik), b. lubiprostone (Amitiza), or c. naldemedine (Symproic). Reauthorization requires documentation of response to therapy (e.g., less straining, less pain on defecation, improved stool consistency, increased number of stools per week or reduction in the number of days between stools)
Age Restrictions	N/A
Prescriber Restrictions	N/A

PA Criteria	Criteria Details
Coverage Duration	Initial authorization and reauthorization will be approved for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rescue Medications for Epilepsy

Products Affected

- Nayzilam
- Valtoco

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist
Coverage Duration	Authorization will be approved until no longer eligible with the plan
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RESPIRATORY BIOLOGICS-FASENRA

Products Affected

- Fasenra Pen

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with anti-IL5 (such as mepolizumab, reslizumab, benralizumab), anti-IgE (such as omalizumab), anti-TSLP (such as tezepelumab), or anti-IL4 (such as dupilumab) monoclonal antibodies

PA Criteria	Criteria Details
Required Medical Information	For initial authorization for asthma, all the following criteria must be met: 1. Diagnosis of severe eosinophilic asthma by one of the following: a. A blood eosinophil count of greater than 150 cells/microliter in the past 12 months, or b. Past history of eosinophilic asthma if currently on daily maintenance treatment with oral glucocorticoids, 2. The patient is currently being treated with, and will continue asthma control therapy in combination with the requested agent, or has an intolerance/ contraindication to standard asthma control therapy. Asthma control therapy may include inhaled corticosteroids (ICS), ICS with long-acting beta agonist (ICS/LABA), leukotriene receptor antagonist (LTRA), long-acting muscarinic antagonist (LAMA), and/or theophylline. 3. Documentation of severe asthma with inadequate control such as frequent exacerbations requiring oral corticosteroids or hospitalizations or a poor asthma control scores (An ACT score less than 20 or an ACQ greater than or equal to 1.5). Reauthorization for asthma: 1. Documentation of positive clinical response to therapy, such as attainment and maintenance of remission or decrease in number of relapses, 2. The patient is currently being treated with, and will continue asthma control therapy in combination with the requested agent, or has an intolerance/ contraindication to standard asthma control therapy (e.g., ICS, ICS/LABA, LRTA, LAMA, theophylline).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, and asthma specialist (such as a pulmonologist, immunologist, or allergist)
Coverage Duration	Initial authorization for one year. Reauthorization until no longer eligible with the plan.

PA Criteria	Criteria Details
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RESPIRATORY BIOLOGICS-NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with anti-IL5 (such as mepolizumab, reslizumab, benralizumab), anti-IgE (such as omalizumab), anti-TSLP (such as tezepelumab), or anti-IL4 (such as dupilumab) monoclonal antibodies

PA Criteria	Criteria Details
Required Medical Information	For initial authorization for asthma, all the following criteria must be met: 1. Diagnosis of severe eosinophilic asthma by one of the following: a. A blood eosinophil count of greater than 150 cells/microliter in the past 12 months, or b. Past history of eosinophilic asthma if currently on daily maintenance treatment with oral glucocorticoids, 2. The patient is currently being treated with, and will continue asthma control therapy in combination with the requested agent, or has an intolerance/ contraindication to standard asthma control therapy. Asthma control therapy may include inhaled corticosteroids (ICS), ICS with long-acting beta agonist (ICS/LABA), leukotriene receptor antagonist (LTRA), long-acting muscarinic antagonist (LAMA), and/or theophylline. 3. Documentation of severe asthma with inadequate control such as frequent exacerbations requiring oral corticosteroids or hospitalizations or a poor asthma control scores (An ACT score less than 20 or an ACQ greater than or equal to 1.5). Reauthorization for asthma: 1. Documentation of positive clinical response to therapy, such as attainment and maintenance of remission or decrease in number of relapses, 2. The patient is currently being treated with, and will continue asthma control therapy in combination with the requested agent, or has an intolerance/ contraindication to standard asthma control therapy (e.g., ICS, ICS/LABA, LRTA, LAMA, theophylline).
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	Medications must be prescribed by, or in consultation with the following specialists based on the diagnosis: 1. Asthma: asthma specialist (such as a pulmonologist, immunologist, or allergist), 2. EGPA: pulmonologist, neurologist, or rheumatologist, 3. HES: hematologist, immunologist, pulmonologist, cardiologist, or neurologist, 4. CRSwNP: otolaryngologist, allergist, or pulmonologist.
Coverage Duration	EGPA/HES/CRSwNP:Initial 6 mo/reauth 1 yr Asthma:Initial 1 yr/reauth until no longer elig with plan

PA Criteria	Criteria Details
Other Criteria	For initial authorization for hypereosinophilic syndrome (HES): 1. Diagnosis of HES (blood eosinophil count of 1,000 cells/microliter or higher for at least six months), without an identifiable non-hematologic secondary cause (such as parasitic infections, solid tumors, or T cell lymphoma), 2. The patient is currently being treated with maximally tolerated oral corticosteroid, unless intolerance/contraindication to oral corticosteroids. Reauthorization for HES: 1. Documentation of positive clinical response to therapy and 2. The patient is currently being treated with maximally tolerated oral corticosteroid, unless intolerance/contraindication to oral corticosteroids. For initial authorization for eosinophilic granulomatosis with polyangiitis (EGPA): 1. Diagnosis of EGPA defined as blood eosinophil level of at least 10% or an absolute eosinophil count of more than 1000 cells/microliter, 2. The patient is currently being treated with maximally tolerated oral corticosteroid, unless intolerance/contraindication to oral corticosteroids. Reauthorization for EGPA: 1. Documentation of positive clinical response to therapy and 2. The patient is currently being treated with maximally tolerated oral corticosteroid, unless intolerance/contraindication to oral corticosteroids. For initial authorization for Chronic Rhinosinusitis with Nasal Polyp (CRSwNP): 1. Evidence of nasal polyposis by direct examination, endoscopy or sinus CT scan and 2. Inadequate response to a three-month trial of intranasal corticosteroids (e.g., fluticasone) or has an intolerance, FDA labeled contraindication, or hypersensitivity to an
	intranasal corticosteroid. Reauthorization for CRSwNP requires documentation of positive clinical response to therapy.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

RESPIRATORY BIOLOGICS-XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with anti-IL5 (such as mepolizumab, reslizumab, benralizumab), anti-IgE (such as omalizumab), anti-TSLP (such as tezepelumab), or anti-IL4 (such as dupilumab) monoclonal antibodies

PA Criteria	Criteria Details
Required Medical Information	For asthma, must meet all the following criteria: 1. Diagnosis of moderate or severe persistent asthma, 2. IgE baseline levels greater than 30 IU/ml, 3. Positive skin test or in vitro reactivity test (RAST) to a perennial aeroallergen, 4. The patient is currently being treated with, and will continue asthma control therapy in combination with the requested agent, or has an intolerance/ contraindication to standard asthma control therapy. Asthma control therapy may include inhaled corticosteroids (ICS), ICS with long-acting beta agonist (ICS/LABA), leukotriene receptor antagonist (LTRA), long-acting muscarinic antagonist (LAMA), and/or theophylline, 5. Documentation of severe asthma with inadequate control such as frequent exacerbations requiring oral corticosteroids or hospitalizations or a poor asthma control scores (An ACT score less than 20 or an ACQ greater than or equal to 1.5). Reauthorization for asthma requires: 1. Documentation of response to therapy, such as attainment and maintenance of remission or decrease in number of relapses and 2. The patient is currently being treated with, and will continue asthma control therapy in combination with the requested agent, or has an intolerance/ contraindication to standard asthma control therapy (e.g., ICS, ICS/LABA, LRTA, LAMA, theophylline).
Age Restrictions	
Prescriber Restrictions	Medications must be prescribed by, or in consultation with the following specialists based on the diagnosis. 1. Asthma: asthma specialist (such as a pulmonologist, immunologist, or allergist), 2. Urticaria: dermatologist, allergist, or immunologist, 3. nasal polyps: otolaryngologist, allergist, or pulmonologist.

PA Criteria	Criteria Details
Coverage Duration	Urticaria/nasal polyp: Init 6mo/reauth 1yr. Asthma: Init 1yr/reauth until no longer elig with plan
Other Criteria	For initial authorization for chronic idiopathic urticaria, must meet all of the following criteria: 1. Documentation that the condition is idiopathic and that secondary causes of urticaria (e.g. offending allergens, physical contact, etc.) have been ruled out, 2. Inadequate response, intolerance, or contraindication to H1 antihistamine. Reauthorization for urticaria will require documentation of response to therapy (e.g. reduction in flares or oral steroid dose). Reauthorization for urticaria requires documentation of positive clinical response to therapy. For initial authorization for nasal polyps, all of the following: 1. Evidence of nasal polyposis by direct examination, endoscopy or sinus CT scan, 2. Inadequate response to a 8 weeks trial of intranasal corticosteroids (e.g., fluticasone) or has an intolerance, FDA labeled contraindication, or hypersensitivity to an intranasal corticosteroid, 3. Documentation that patient will continue to use intranasal corticosteroids in combination with the requested agent, unless intolerance, FDA labeled contraindication, or hypersensitivity to an intranasal corticosteroid. Reauthorization for nasal polyps: 1. Documentation of positive clinical response to therapy, 2. Documentation that patient will continue standard maintenance therapy (e.g., intranasal corticosteroids) in combination with the requested agent, unless documented intolerance, FDA labeled contraindication, or hypersensitivity to such therapy.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

SAPROPTERIN

Products Affected

- sapropterin

PA Criteria	Criteria Details
Exclusion Criteria	Doses greater than 20mg/kg/day will not be approved. Use in combination with pegvalise-pqpz (Palynziq).
Required Medical Information	Initial authorization: 1. Diagnosis of phenylketonuria (PKU) AND 2. Documentation that the patients pre-treatment phenylalanine blood levels measured within 90 days prior to starting therapy is above 6 mg/dL (360 micromol/L) in children less than 12 years of age, or above 10 mg/dL (600 micromol/L) for ages 12 and older. Reauthorization requires improvement in average blood Phe level from pretreatment baseline.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a specialist in metabolic disorders
Coverage Duration	Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For initial authorization all of the following criteria must be met: 1. Diagnosis of acromegaly, 2. Documentation that the patient has persistent disease (e.g., biochemical or clinical) following surgical resection or patient is ineligible for surgery, AND 3. Documentation of trial and failure, intolerance or contraindication to octreotide injection therapy. Reauthorization requires documentation of a positive response to therapy, such as a decrease or normalization of insulin like growth factor (IGF)-1.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial authorization and reauthorization will be approved for one year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

TADALAFIL

Products Affected

- tadalafil oral tablet 2.5 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	Use for sexual dysfunction without comorbid diagnosis of benign prostatic hypertrophy (BPH)
Required Medical Information	Documentation of confirmed diagnosis of benign prostatic hyperplasia (BPH).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be approved until no longer eligible with the plan.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TAFAMIDIS

Products Affected

- Vyndamax
- Vyndaqel

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Initial authorization, all the following must be met: 1. Confirmation of amyloid deposits showing cardiac involvement by ONE of the following: a. A positive radionuclide imaging scan, defined as showing Grade 2 or 3 cardiac uptake using one of the following radiotracers: i. 99m technetium-Pyrophosphate (99mTc-PYP), ii. 99m technetium (Tc)-labeled 3,3-diphosphono-1,2-propanodicarboxylic acid (99mTc-DPD), iii. 99m Tc-labeled hydroxymethylene diphosphonate (HMDP), b. A positive cardiac biopsy for ATTR amyloid, OR c. A positive non-cardiac biopsy for ATTR amyloid and evidence of cardiac involvement by end-diastolic interventricular septal wall thickness greater than 12 mm (by echocardiogram or MRI) or suggestive cardiac MRI findings, AND 2. Documentation of patients NYHA functional class (functional class IV is excluded from coverage), AND 3. Documentation of clinical signs or symptoms of cardiomyopathy and/or heart failure such as dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema, elevated BNP or NT-BNP levels. Reauthorization requires documentation of a positive clinical response. Appropriate documentation may include evidence of slowing of clinical decline, reduced number of cardiovascular hospitalizations, or improvement or stabilization of the 6-minute walk test.

PA Criteria	Criteria Details
Age Restrictions	Approved for patients 18 years of age and older
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist or a physician who specializes in the treatment of amyloidosis
Coverage Duration	Initial authorization and reauthorization will be approved for one year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TAVALISSE

Products Affected

- Tavalisse

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For initial authorization all of the following criteria must be met: 1. Diagnosis of chronic immune thrombocytopenia (ITP), 2. Platelet count of less than 30,000 per microliter, and 3. Inadequate response to at least TWO of the following therapies: a. Corticosteroids b. Immunoglobulins c. Splenectomy d. Thrombopoietin receptor agonists e. Rituximab. Reauthorization requires documentation of an improvement in platelet count to at least 50,000 per microliter.
Age Restrictions	Approved for patients 18 years of age and older
Prescriber Restrictions	Must be prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Initial authorization will be approved for 3 months. Reauthorization will be approved for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

TESTOSTERONE REPLACEMENT THERAPY

Products Affected

- testosterone cypionate
- testosterone transdermal gel
- testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)
- testosterone transdermal gel in packet
- testosterone transdermal solution in metered pump w/app

PA Criteria	Criteria Details
Exclusion Criteria	Use exclusively for improvement of sexual signs and symptoms (e.g., decreased libido, sexual dysfunction)

PA Criteria	Criteria Details
Required Medical Information	For patients established on testosterone replacement therapy and requesting use of a different testosterone replacement product than currently established on: Documented trial and failure of generic topical testosterone 1%. Failure is defined as inability to reach therapeutic levels or fluctuations in levels resulting in symptoms. For initiation of testosterone replacement therapy, all of the following criteria must be met: 1. Diagnosis of primary or secondary (hypogonadatropic) hypogonadism, AND 2. One of the following confirmatory laboratory values, taken before 11 am (or within 3 hours of waking for shift-workers) on different days without acute illness/stress, according to the local laboratorys lower limit of normal (if available) or levels according to the listed values below: a. At least two (2) serum total testosterone levels less than 264 ng/dL (9.2 nmol/L), b. At least two (2) free testosterone levels less than 2 ng/dL (20 pg/mL), c. At least one (1) serum total testosterone level less than 264 ng/dL (9.2 nmol/L), AND one (1) free testosterone levels less than 2 ng/ dL (20 pg/mL). Serum total testosterone level and free testosterone level must be taken on different days. AND 3. Documentation of trial and failure, contraindication or intolerance to generic topical testosterone 1% gel. Failure is defined as inability to reach therapeutic levels or fluctuations in levels resulting in symptoms.
Age Restrictions	Approved for adults 18 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	Initial authorization and reauthorization will be approved until no longer eligible with the plan

PA Criteria	Criteria Details
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

THERAPEUTIC IMMUNOMODULATORS

Products Affected

- Cosentyx (2 Syringes)
- Cosentyx Pen
- Cosentyx Pen (2 Pens)
- Cosentyx subcutaneous
- Cosentyx UnoReady Pen
- Enbrel Mini
- Enbrel subcutaneous solution
- Enbrel subcutaneous syringe
- Enbrel SureClick
- Humira Pen
- Humira Pen Crohns-UC-HS Start
- Humira Pen Psor-Uveits-Adol HS
- Humira subcutaneous syringe kit 40 mg/0.8 mL
- Humira(CF)
- Humira(CF) Pedi Crohns Starter
- Humira(CF) Pen
- Humira(CF) Pen Crohns-UC-HS
- Humira(CF) Pen Psor-Uv-Adol HS
- Otezla
- Otezla Starter oral tablets,dose pack 10 mg (4)-20 mg (4)-30 mg (47)
- Rinvoq
- Skyrizi subcutaneous pen injector
- Skyrizi subcutaneous syringe 150 mg/mL
- Skyrizi subcutaneous wearable injector
- Stelara subcutaneous
- Tremfya
- Xeljanz
- Xeljanz XR

PA Criteria	Criteria Details
Exclusion Criteria	Patient is currently being treated with another therapeutic immunomodulator or apremilast

PA Criteria	Criteria Details
Required Medical Information	For patients already established on the requested therapy: 1. Documentation of response to therapy (i.e. slowing of disease progression or decrease in symptom severity and/or frequency), AND 2. One of the following: a. Patient is not currently being treated with another therapeutic immunomodulator, OR b. Patient is currently being treated with another therapeutic immunomodulator AND will discontinue the other therapeutic immunomodulator. For patients being initiated on therapy, all of the following criteria must be met: 1. Patient must have an FDA labeled indication for the requested agent, AND 2. For Rinvoq/Xeljanz/Xeljanz XR: Documentation of trial and failure, intolerance, or contraindication to a preferred TNF agent (see notes below), AND 3. Documentation of trial and failure, intolerance, or contraindication to conventional therapy prerequisite(s) for the requested indication (see notes below), AND 4. One of the following: a. Patient is not currently being treated with another therapeutic immunomodulator, OR b. Patient is currently being treated with another therapeutic immunomodulator AND will discontinue the other therapeutic immunomodulator prior to starting the requested agent.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial auth approved for 1 year. Reauth will be approved until no longer eligible with the plan

PA Criteria	Criteria Details
Other Criteria	Notes: Use of ONE conventional prerequisite agent is required for diagnoses of psoriatic arthritis, plaque psoriasis, rheumatoid arthritis, and juvenile idiopathic arthritis. Use of TWO conventional prerequisite agents is required for atopic dermatitis, specifically ONE formulary topical corticosteroid AND ONE formulary topical calcineurin inhibitor. NO conventional prerequisites are required for diagnoses of ankylosing spondylitis, hidradenitis suppurativa, ulcerative colitis, Crohn's disease, enthesitis related arthritis, non-radiographic axial spondyloarthritis, or uveitis. For Rinvoq: Use of ONE preferred TNF (etanercept or adalimumab) is required for diagnoses of ankylosing spondylitis, rheumatoid arthritis, or psoriatic arthritis. Only preferred TNF adalimumab is required for diagnosis of ulcerative colitis or Crohns disease. For Xeljanz/Xeljanz XR: Use of ONE preferred TNF (etanercept or adalimumab) is required for diagnoses of psoriatic arthritis, rheumatoid arthritis, juvenile idiopathic arthritis, or ankylosing spondylitis. Only preferred TNF adalimumab is required for diagnosis of ulcerative colitis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOLVAPTAN

Products Affected

- tolvaptan

PA Criteria	Criteria Details
Exclusion Criteria	Hepatic impairment, anuria, hypovolemia, for Tolvaptan. Patients with eGFR of less than 25 mL/min.
Required Medical Information	For hypervolemic and euvolemic hyponatremia, tolvaptan can be covered when all of the following criteria are met: 1. One of the following: a. Serum sodium of less than 125 mEq/L, b. Less marked hyponatremia (less than 135 mEq/L), but symptomatic, AND 2. Evidence that initiation and re-initiation of therapy in a hospital setting where serum sodium can be monitored closely, AND 3. Patient does not have an urgent need to raise serum sodium acutely (such as acute/transient hyponatremia associated with head trauma)
Age Restrictions	Approved for patients 18 years of age and older
Prescriber Restrictions	Must be prescribed by, or in consultation with, a nephrologist, cardiologist or endocrinologist.
Coverage Duration	Tolvaptan: approved for 30 days and reauthorization approved for 1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

TRIENTINE

Products Affected

- Syprine
- trientine oral capsule 250 mg

PA Criteria	Criteria Details
Exclusion Criteria	Cystinuria or rheumatoid arthritis
Required Medical Information	Confirmed diagnosis of Wilsons Disease.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, a gastroenterologist, medical geneticist, or hepatologist.
Coverage Duration	Initial authorization and reauthorization will be approved for one year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VERQUVO

Products Affected

- Verquvo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For chronic heart failure, all of the following criteria must be met: 1. Documentation of symptomatic heart failure (NYHA Class II-IV) with a left ventricular ejection fraction (LVEF) less than 45% 2. On maximally tolerated guideline-directed therapy including both of the following, unless contraindicated or not tolerated: a. Beta-blocker (specifically carvedilol, metoprolol succinate, or bisoprolol) b. One of the following: i. Angiotensin-converting enzyme (ACE) inhibitor (such as lisinopril, enalapril) ii. Angiotensin II receptor blocker (ARB) (such as losartan, valsartan) iii. Angiotensin receptor-neprilysin inhibitor (ARNI) (sacubitril/valsartan), unless not tolerated or contraindicated, 3. Documentation of clinical worsening of heart failure, defined as one of the following, despite maximal therapy as outlined above: a. Hospitalization for heart failure within the previous six months b. Need for outpatient intravenous diuretic therapy within the previous three months
Age Restrictions	Approved for adults 18 years of age and older
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist

PA Criteria	Criteria Details
Coverage Duration	Authorization will be approved until no longer eligible with the plan
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VIBERZI

Products Affected

- Viberzi

PA Criteria	Criteria Details
Exclusion Criteria	Patients without a gallbladder.
Required Medical Information	For initial authorization, all the following must be met: 1. Diagnosis of Irritable Bowel Syndrome with Diarrhea (IBS-D), AND 2. Documentation of trial and failure, contraindication, or intolerance to loperamide.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	Authorization will be approved until no longer eligible with the plan.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VIJOICE

Products Affected

- Vijoice

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial authorization requires criteria 1-3 to be met: 1. Confirmed diagnosis of PIK3CA-related overgrowth spectrum (PROS) as defined by meeting criteria A-D: A. Presence of somatic PIK3CA mutation B. Congenital or early childhood onset C. Overgrowth sporadic or mosaic (other terms: patchy, irregular) D. Clinical features as described in either a or b: a. Spectrum (require two or more of the following): i. Overgrowth (adipose, muscle, nerve, skeletal) ii. Vascular malformations (capillary, venous, arteriovenous malformations, lymphatic) iii. Epidermal nevus b. Isolated features (one of the following): i. Large isolated lymphatic malformation ii. Isolated macrodactyly OR overgrown splayed feet/hands, overgrown limbs iii. Truncal adipose overgrowth iv. Hemimegalencephaly (bilateral)/dysplastic megalencephaly/focal cortical dysplasia v. Epidermal nevus vi. Seborrheic keratoses vii. Benign lichenoid keratoses large, AND 2. Patient has at least one target lesion identified on imaging, AND 3. Patient's condition is severe or life-threatening and treatment is deemed necessary as determined by the treating physician. Reauthorization requires documentation of positive response to therapy such as reduction in the sum of measurable target lesion volume.

PA Criteria	Criteria Details
Age Restrictions	Approved for patients 2 years of age and older
Prescriber Restrictions	Must be prescribed by, or in consultation with, a specialist in treating PROS.
Coverage Duration	Initial authorization and reauthorization will be approved for six months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VMAT-2 INHIBITORS

Products Affected

- Austedo
- Austedo XR
- Austedo XR Titration Kt(Wk1-4)
- Ingrezza
- Ingrezza Initiation Pack
- tetrabenazine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For chorea associated with Huntington disease, the following criteria must be met: 1. Diagnosis of Huntington disease as defined by all of the following: a. DNA testing showing CAG expansion of 36 or higher, b. Family history (if known), and c. Classic presentation (choreiform movements, psychiatric problems, and dementia), and 2. For coverage of deutetrabenazine (Austedo), documented trial (of at least 8 weeks) and failure or intolerance of tetrabenazine. For tardive dyskinesia, all of the following criteria must be met: 1. Diagnosis of tardive dyskinesia secondary to therapy with a dopamine receptor blocking agent (e.g. first or second generation antipsychotics, metoclopramide), 2. Documentation of moderate to severe tardive dyskinesia that is causing functional impairment, 3. For coverage of deutetrabenazine (Austedo) and valbenazine (Ingrezza): Documented trial (of at least 8 weeks) and failure or intolerance of tetrabenazine. Reauthorization requires documentation of positive clinical response to therapy, such as improved function.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, a neurologist or psychiatrist

PA Criteria	Criteria Details
Coverage Duration	Initial authorization will be approved for 3 months. Reauthorization will be approved for 1 year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

WAKEFULNESS PROMOTING AGENT-SUNOSI

Products Affected

- Sunosi

PA Criteria	Criteria Details
Exclusion Criteria	Idiopathic central nervous system hypersomnia
Required Medical Information	For Type 2 narcolepsy (excessive daytime sleepiness in narcolepsy without cataplexy), all the following criteria must be met: 1. Diagnosis of narcolepsy as confirmed by sleep study or low orexin/hypocretin levels on a cerebrospinal fluid (CSF) assay (less than 110 pg/mL or less than one third of the normative values with the same standardized assay), 2. Documentation of daily periods of irrepressible need to sleep/daytime lapses into sleep occurring for at least three (3) months, 3. Other causes of sleepiness have been ruled out or treated (such as shift work, effects of substances or medications or their withdrawal, other sleep disorders), 4. For adult patients: documentation of a 30-day trial and failure, intolerance, or contraindication to modafinil or armodafinil. For excessive sleepiness due to Obstructive Sleep Apnea (OSA), all the following criteria must be met: 1. Diagnosis of OSA as confirmed by sleep study and 2. Documented trial and failure, intolerance or contraindication of armodafinil or modafinil. Reauthorization for all indications requires documentation of successful response to the medication, such as a reduction in symptoms of excessive daytime sleepiness.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	Must be prescribed by, or in consultation with, a sleep specialist, neurologist, pulmonologist, or psychiatrist
Coverage Duration	Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

WAKEFULNESS PROMOTING AGENT-WAKIX

Products Affected

- Wakix

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	For Type 1 narcolepsy (narcolepsy with cataplexy), all the following criteria must be met: 1. Diagnosis of narcolepsy as confirmed by sleep study or low orexin/hypocretin levels on a cerebrospinal fluid (CSF) assay (less than 110 pg/mL or less than one-third of the normative values with the same standardized assay), 2. Documentation of daily periods of irrepressible need to sleep/daytime lapses into sleep occurring for at least three (3) months, 3. Documentation of at least three (3) weekly cataplexy attacks. For Type 2 narcolepsy (excessive daytime sleepiness in narcolepsy without cataplexy), all the following criteria must be met: 1. Diagnosis of narcolepsy as confirmed by sleep study or low orexin/hypocretin levels on a cerebrospinal fluid (CSF) assay (less than 110 pg/mL or less than one third of the normative values with the same standardized assay), 2. Documentation of daily periods of irrepressible need to sleep/daytime lapses into sleep occurring for at least three (3) months, 3. Other causes of sleepiness have been ruled out or treated (such as obstructive sleep apnea, shift work, effects of substances or medications or their withdrawal, other sleep disorders), 4. For adult patients: documentation of a 30-day trial and failure, intolerance, or contraindication to modafinil or armodafinil. Reauthorization for all indications requires documentation of successful response to the medication, such as a reduction in symptoms of excessive daytime sleepiness or reduction in frequency of cataplexy attacks, if applicable.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, a sleep specialist, neurologist, pulmonologist, or psychiatrist
Coverage Duration	Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

PA Criteria	Criteria Details
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

WAKEFULNESS PROMOTING AGENT-XYWAV/SODIUM OXYBATE

Products Affected

- sodium oxybate
- Xywav

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	For Type 1 narcolepsy (narcolepsy with cataplexy), all the following criteria must be met: 1. Diagnosis of narcolepsy as confirmed by sleep study or low orexin/hypocretin levels on a cerebrospinal fluid (CSF) assay (less than 110 pg/mL or less than one-third of the normative values with the same standardized assay), 2. Documentation of daily periods of irrepressible need to sleep/daytime lapses into sleep occurring for at least three (3) months, 3. Documentation of at least three (3) weekly cataplexy attacks, 4. For adult patients: documentation of a 30-day trial and failure, intolerance, or contraindication to pitolisant (Wakix). For Type 2 narcolepsy (excessive daytime sleepiness in narcolepsy without cataplexy), all the following criteria must be met: 1. Diagnosis of narcolepsy as confirmed by sleep study or low orexin/hypocretin levels on a cerebrospinal fluid (CSF) assay (less than 110 pg/mL or less than one third of the normative values with the same standardized assay), 2. Documentation of daily periods of irrepressible need to sleep/daytime lapses into sleep occurring for at least three (3) months, 3. Other causes of sleepiness have been ruled out or treated (such as obstructive sleep apnea, shift work, effects of substances or medications or their withdrawal, other sleep disorders), 4. For adult patients: documentation of a 30-day trial and failure, intolerance, or contraindication to modafinil or armodafinil.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, a sleep specialist, neurologist, pulmonologist, or psychiatrist
Coverage Duration	Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

PA Criteria	Criteria Details
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	All the following criteria must be met: 1. Diagnosis of carcinoid syndrome diarrhea, 2. Inadequately controlled diarrhea despite use, for at least three months, of a long-acting somatostatin analog therapy such as octreotide LAR (Sandostatin LAR) or lanreotide (Somatuline) 3. Documentation that long-acting somatostatin analog therapy will be used in combination with the requested medication. Reauthorization will require documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with an oncologist or gastroenterologist.
Coverage Duration	Initial authorization and reauthorization will be approved for one year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For prevention of skeletal-related events in patients with bone metastases from solid tumors: Documented trial and failure of, intolerance to, or contraindication to zoledronic acid or pamidronate therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial authorization and reauthorization will be approved for one year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XIFAXAN

Products Affected

- Xifaxan

PA Criteria	Criteria Details
Exclusion Criteria	More than 3 treatment courses in a rolling 6-month period for IBS-D
Required Medical Information	For traveler's diarrhea (200 mg tablets): Diagnosis of travelers diarrhea caused by noninvasive strains of Escherichia coli. Rifaximin is not covered if documentation shows diarrhea that is complicated by fever or blood in stool. For hepatic encephalopathy (HE) (550 mg tablets): Documentation of trial and failure, contraindication or intolerance to lactulose. For irritable bowel syndrome with diarrhea (IBS-D) (550 mg tablets) with or without small intestinal bacterial growth (SIBO): Documentation of trial and failure, contraindication, or intolerance to a tricyclic antidepressant (e.g. amitriptyline). Reauthorization in IBS-D requires documentation of initial response to treatment with rifaximin and recurrence of IBS-D symptoms. Limited to three (3) total 14-day course treatments (initial treatment and two reauthorizations).
Age Restrictions	N/A
Prescriber Restrictions	For irritable bowel syndrome with diarrhea (IBS-D): Must be prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	Travelers diarrhea: 3 days, IBS-D: 14 days, HE: until no longer eligible with the plan

PA Criteria	Criteria Details
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ZTALMY

Products Affected

- Ztalmy

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initiation of therapy, all the following criteria must be met: 1. Diagnosis of CDKL5 deficiency disorder (CDD) as confirmed with genetic testing 2. Documented trial and failure with two or more antiepileptic drugs 3. Documentation that it will be used as adjunctive therapy with other antiepileptic drugs
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, an epilepsy specialist or neurologist
Coverage Duration	Authorization will be approved until no longer eligible with the plan.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No